



## Summary Plan Description



## The Flexible Benefits Plan



## **Flexible Benefits Plan**

### **About This Insert**

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This Insert is part of your Flexible Benefits Plan Summary Plan Description (SPD), and details Plan provisions specific to your coverage, effective January 1, 2010, that are not outlined in the SPD. It is part of the Plan document and should be kept with your SPD.

### **Eligibility**

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You are eligible to participate in The Flexible Benefits Plan if you are a full- or part-time management, specialist, administrative or technical employee of one of the United Parcel Service affiliates (the Company) listed below and your terms of employment are not subject to collective bargaining. Part-time employees must be regularly scheduled to work at least 15 hours per week to be eligible.

- United Parcel Service General Services Co.
- UPS Fuel Services, Inc.
- UPS Capital Trade Protection Services, Inc.
- UPS Capital Insurance Agency, Inc.
- UPS Customhouse Brokerage, Inc.
- UPS Global Innovations, Inc.
- UPS Supply Chain Solutions General Services, Inc.
- UPS International General Services Co.
- UPS Procurement Services Corporation
- UPS Worldwide Forwarding, Inc.
- United Parcel Service, Inc. (Ohio)
- BT Realty Holdings, Inc.
- BT Realty Holdings II, Inc.
- Trailer Conditioners, Inc. (exempt only)
- Mail Boxes Etc., Inc.

You're not eligible to participate if you are:

- a full- or part-time administrative or technical employee of Trailer Conditioners, Inc.;
- a temporary employee, intern or co-op;
- a UPS employee in Puerto Rico, the Virgin Islands, Canada or any country other than the United States, except for employees of International General Services; or
- an employee covered by a collective bargaining agreement.

### **Medical Opt-Out Credit**

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If you choose not to elect medical coverage, you receive an opt-out credit as taxable income. However, to receive these credits, you must certify that you have medical coverage elsewhere. Without this certification, no credits will be provided in lieu of electing medical coverage. See your enrollment information for credit amounts.

## **Income Protection Plan: Short-Term Disability (STD)**

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Short-term disability coverage is available to all full-time and part-time employees eligible for The Flexible Benefits Plan when coverage begins under the Plan. The Plan pays a percentage of your base pay for any one continuous period of disability, up to the maximum STD benefit period for your job classification, as indicated below.

### ***Administrative or Technical Employees (Hourly Paid)***

The Plan pays disability benefits for a maximum of 26 weeks, at 100 percent of your base pay for up to 13 weeks and 60 percent of your base pay for any remaining weeks during that same approved disability period.

Aetna Disability and Absence Management (ADAM) will administer your STD benefit payments. You will be billed by the Benefits Service Center for your share of the cost of your Flexible Benefits Plan coverage.

STD benefits are taxed when paid to you. If you are an administrative or technical employee (hourly paid), ADAM will issue all W-2 forms for any benefits received under the STD Plan.

### ***Management or Specialist Employees***

The Plan pays 100 percent of your base pay for up to 26 weeks. You will continue to receive your check from the Company, with your usual payroll deductions, during the time you are approved for STD benefits. Aetna Disability and Absence Management (ADAM) will administer your STD benefit payments and assign a case manager to work with you.

STD benefits are taxed when paid to you. If you are a management or specialist employee (salaried), the Company will issue all W-2 forms.

## Summary of Material Modifications

### The Flexible Benefits Plan

October 2013



*This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2014, unless otherwise noted below. Items marked with an asterisk (\*) do not apply to COBRA participants. You should keep this with your Flexible Benefits Plan Summary Plan Description (SPD) for future reference. The terms of the Plan are not changing and remain in full force and effect, except as specifically described in this Summary.*

#### **Working Spouse Eligibility\***

Effective January 1, 2014, spouses and same-sex domestic partners or civil union partners (as defined by the Plan) who are “eligible” for coverage as an employee (other than as a qualified beneficiary under COBRA) under another employer’s medical plan (e.g., the spouse’s employer’s plan) are not eligible for medical coverage under The Flexible Benefits Plan to the extent that such coverage constitutes minimum essential coverage (for purposes of the individual mandate under the Affordable Care Act). For this purpose, a spouse, domestic partner or civil union partner is considered eligible for other employer coverage if the spouse, domestic partner or civil union partner satisfies the terms of eligibility to participate in the Plan as an employee (other than COBRA coverage), even if not otherwise permitted to currently enroll. However, if the spouse is subject to a waiting period, the spouse will not be considered to be eligible for other employer coverage during the waiting period.

The spousal exclusion applies without regard to the cost of the other medical coverage, or the scope of the medical coverage. However, if the only coverage for which the spouse is eligible is any of the following, the spousal exclusion does not apply:

- Continuation of coverage under COBRA
- Dental
- Vision
- Health flexible spending account (FSA)
- Employee assistance program (EAP)
- Health savings account (assuming that the spouse, domestic partner or civil union partner is not also eligible or enrolled in the employer’s high deductible health plan)
- Any benefit that does not qualify as minimum essential coverage for purposes of the individual mandate (such as fixed indemnity or specified disease policy).

Minimum essential coverage may not be affordable and it may **not** provide minimum value as defined by the Affordable Care Act (ACA). The Summary of

Benefits and Coverage (SBC) provided by your employer will indicate whether or not the coverage is minimum essential coverage. You can also contact your employer for this information.

If your spouse, domestic partner or civil union partner is enrolled in The Flexible Benefits Plan and later becomes eligible for other employer coverage, it is your responsibility to notify the Plan immediately that your spouse, domestic partner or civil union partner is no longer eligible for coverage under the Plan.

If your spouse, domestic partner or civil union partner loses eligibility for other employer coverage, you may request enrollment. See the *Life Events* section of the Plan’s SPD for more detail.

#### **Tobacco Cessation Incentive Program\***

UPS is offering a UPS Tobacco Cessation Incentive Program (“Program”) to help improve the health and wellness of UPSers and their families. As part of the Program, you pay a lower premium if you have not used tobacco products in the last 12 months or, if you have, you complete the UPS-sponsored tobacco cessation program, Quit for Life®.

#### **Eligibility**

As an active employee, you and your spouse, domestic partner or civil union partner are eligible for this Program if eligible for, and enrolled in, the medical portion of the Plan. Under this Program, you pay a lower premium for medical coverage under the Plan if you “participate” in the Program.

#### **Participation**

You participate in this Program if you satisfy the following conditions:

- You certify your tobacco use status and that of your spouse, domestic partner or civil union partner (if applicable) enrolling in the Plan; and
- If certified as a tobacco user, you and/or your spouse, domestic partner or civil union partner enroll in and complete the Quit For Life program.

The specific terms of the Program are described in the UPS Tobacco Cessation Incentive Program document, available at [www.UPSers.com](http://www.UPSers.com).

### **Medical Benefits: Opt-Out Credit**

Effective January 1, 2014, UPS will no longer pay an opt-out credit for employees who do not enroll in medical coverage.

### **Two-Year Rule for Dental and Vision Benefits**

The two-year rule for dental and vision coverage, which requires you to maintain your coverage election for two years, will no longer apply beginning January 1, 2014. You will be able to change your dental and vision coverage election every year during annual enrollment. You cannot change your dental and vision coverage during the year unless you experience a Life Event.

### **Vision Benefits**

*The following language is a clarification of current Plan administration.*

The Plan will cover up to the Vision Service Plan (VSP) plan limits for disposable contact lenses in lieu of glasses. That limit is currently \$150 if purchased through a VSP in-network provider.

### **Spending Accounts**

#### **Health Savings Account (HSA) and Limited Purpose Spending Account (LPSA)**

The maximum allowable annual contribution employees may make to their HSA will be \$3,300 for individual coverage or \$6,550 for family coverage. The maximum allowable HSA catch-up contribution for individuals age 55 and older remains at an additional \$1,000 per year.

Effective January 1, 2014, prior to making any contributions to a LPSA, you will be required to contribute the maximum contribution to the HSA.

#### **Health Care Spending Account (HCSA) and Approved Leaves of Absence**

If you are a non-union employee on an approved medical leave (other than a FMLA qualifying leave) or Workers' Compensation leave, you are eligible to continue your contribution to your HCSA during your leave on an after-tax basis. You must elect to continue your contribution to your HCSA in order for any eligible expenses incurred during your leave to be eligible for reimbursement.

### **Filing a Claim**

Claims filed under fraudulent pretenses (including any portion of the expense that is otherwise a covered expense) will not be covered under the Plan.

In addition, Plan coverage for you or your dependent may be terminated if you or your dependent submits,

directly or through a provider, a fraudulent, misrepresented or altered claim. Plan coverage may also be terminated if:

- You or your dependent allows another party not covered under the Plan to use your coverage or your dependent's coverage,
- You knowingly enroll an ineligible dependent in the Plan, **or**
- You do not remove an ineligible dependent from coverage.

### **Eligibility: Dependents Eligible for Coverage**

As part of the continued implementation of the ACA, also known as "health care reform," effective January 1, 2014, eligible children under the age of 26 are eligible for coverage under this Plan, even if the child is eligible for medical coverage from his or her own employer-sponsored plan.

### **Eligibility: Qualified Medical Child Support Order**

If you wish to submit a medical child support order or to request a copy of the Plan's policies and procedures for determining whether an order is "qualified" in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), the address has been changed to the following:

UPS Benefits Service Center  
Attention: Qualified Order Team  
PO Box 1542  
Lincolnshire IL 60069-1542

### **Minimum Essential Coverage**

The medical plan coverage provided through the Plan constitutes minimum essential coverage for purposes of the individual mandate applicable to you beginning on January 1, 2014, as required by the ACA.

### **HIPAA Certificate of Creditable Coverage**

As required by the Health Insurance Portability and Accountability Act (HIPAA), UPS automatically sends Certificates of Creditable Coverage in the following instances:

- When you or a dependent loses health coverage under the Plan, without regard to whether you are eligible for COBRA or not.
- When you lose COBRA continuation coverage.

In addition, you may request a Certificate of Creditable Coverage at any time within 24 months of losing coverage under the Plan. If you wish to request a Certificate of Creditable Coverage, please call the UPS Benefits Service Center at 1-800-UPS-1508.

### **Grandfathered Plan Status**

The medical plan is a "grandfathered health plan" under the ACA. Being a grandfathered health plan

means that your Plan may not include certain consumer protections of the ACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the ACA; for example, the elimination of lifetime limits on essential health benefits (as defined by the ACA).

Questions regarding which protections apply and which do not apply to cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 1-800-UPS-1508. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

### **Women's Health Rights**

The Women's Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of all stages of a mastectomy, including lymphedemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

## Summary of Material Modifications

The Flexible Benefits Plan  
September 2012



*This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2013, unless otherwise noted below. You should keep this with your Flexible Benefits Plan Summary Plan Description for future reference. The terms of the Plan are not changing and remain in full force and effect, except as specifically described in this Summary.*

### Preventive Medical Care Guidelines

The chart below replaces the current one in your Summary Plan Description. As an improvement to the guidelines, routine physicals are covered once every year for participants age 7 up to age 50, instead of every other year.

#### Guidelines for Children

Age	Birth up to Age 1	Age 1 up to Age 3	Age 3 up to Age 7	Age 7 up to Age 20
<b>Visits</b>	1 well child	3 well child	1 well child	1 routine physical
<b>Frequency</b>			Every year	Every year
<b>Immunizations</b>	Per current guidelines	Per current guidelines	Per current guidelines	Per current guidelines
<b>Tests</b>	<ul style="list-style-type: none"> <li>Hemoglobin and Hematocrit</li> <li>Tuberculin skin test</li> <li>PKU</li> </ul>	<ul style="list-style-type: none"> <li>Hemoglobin and Hematocrit</li> <li>Tuberculin skin test</li> </ul>	<ul style="list-style-type: none"> <li>Hemoglobin and Hematocrit</li> <li>Tuberculin skin test</li> <li>Hearing screening</li> </ul>	<ul style="list-style-type: none"> <li>Hemoglobin and Hematocrit</li> <li>Tuberculin skin test</li> </ul>
<b>Females only</b>	N/A	N/A	N/A	<ul style="list-style-type: none"> <li>Gyn. exam every year 18 and older</li> <li>Pap smear</li> <li>Breast exam</li> </ul>
<b>Males only</b>	N/A	N/A	N/A	<ul style="list-style-type: none"> <li>Testicular exam</li> </ul>

#### Guidelines for Adults

Age	Age 20 up to Age 30	Age 30 up to Age 40	Age 40 up to Age 50	Age 50 and Older
<b>Visits</b>	1 routine physical	1 routine physical	1 routine physical	1 routine physical
<b>Frequency</b>	Every year	Every year	Every year	Every year
<b>Immunizations</b>	<ul style="list-style-type: none"> <li>DPT</li> <li>MMR</li> </ul>	<ul style="list-style-type: none"> <li>DPT</li> <li>MMR</li> </ul>	<ul style="list-style-type: none"> <li>DPT</li> <li>MMR</li> </ul>	<ul style="list-style-type: none"> <li>DPT</li> <li>MMR</li> </ul>
<b>Tests</b>	<ul style="list-style-type: none"> <li>CBC</li> </ul>	<ul style="list-style-type: none"> <li>CBC</li> </ul>	<ul style="list-style-type: none"> <li>CBC</li> <li>Occult blood</li> </ul>	<ul style="list-style-type: none"> <li>CBC</li> <li>Occult blood</li> </ul>
<b>Females only</b>	<ul style="list-style-type: none"> <li>Gyn. exam every year 18 and older</li> <li>Pap smear</li> <li>Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>Gyn. exam every year 18 and older</li> <li>Pap smear</li> <li>Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>Gyn. exam every year 18 and older</li> <li>Pap smear</li> <li>Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>Gyn. exam every year 18 and older</li> <li>Pap smear</li> <li>Breast exam</li> </ul>
<b>Males only</b>	<ul style="list-style-type: none"> <li>Testicular exam</li> </ul>	<ul style="list-style-type: none"> <li>Testicular exam</li> </ul>	<ul style="list-style-type: none"> <li>Testicular exam</li> <li>PSA</li> </ul>	<ul style="list-style-type: none"> <li>Testicular exam</li> <li>PSA</li> </ul>

### Dental Benefits

There are changes to the fully insured Dental Maintenance Organization (DMO) option provided by Aetna. Current DMO participants will receive a separate notice describing these changes and a new DMO Certificate of Coverage from Aetna if they

continue enrollment in the DMO for 2013. Specific benefit levels and coverage in the DMO is determined by Aetna's Certificate of Coverage. If there is a discrepancy between the information contained in the Flexible Benefits Plan Summary Plan Description (including this SMM) and the Aetna

Certificate of Coverage, the Aetna Certificate of Coverage controls.

### **Prescription Drug Benefits**

CVS Caremark will replace Express Scripts/Medco as the new prescription drug benefits administrator for The Flexible Benefits Plan. Your prescription drug benefits under the Plan are not changing.

If you have questions about your prescription drug benefits, you should call Express Scripts/Medco at 1-800-346-1327 through December 31, 2012. Beginning January 1, 2013, contact CVS Caremark directly by phone at 1-855-282-8412, or online at [www.caremark.com](http://www.caremark.com).

### **Filing a Claim with Caremark**

Effective January 1, 2013, prescriptions for maintenance or long-term medications may be purchased either from a CVS/pharmacy retail store, or mailed to:

CVS Caremark  
P.O. Box 94467  
Palatine, IL 60094-4467

The mail order benefit levels apply regardless of whether the maintenance prescription is filled at a CVS/pharmacy or by mail from CVS Caremark.

First-level appeals for claims administered by CVS Caremark should be mailed to:

CVS Caremark  
Appeals Department  
MC109  
P.O. Box 52084  
Phoenix, AZ 85072-2084

### **Plan Administration**

Effective January 1, 2013, prescription drug benefits are administered by:

CVS Caremark  
One CVS Drive  
Woonsocket, RI 02895

### **Long-Term Disability**

#### **New Disabilities Arising on or After January 1, 2013**

Effective January 1, 2013, Aetna® will become the new long-term disability (LTD) benefit insurance carrier for the Plan *with respect to new disabilities that arise on or after January 1, 2013*. All benefits insured by Aetna will be provided in accordance with insurance documents provided by Aetna. Although the insurance carrier for such disabilities is changing from MetLife to Aetna, the LTD benefits provided by Aetna are not substantially changing.

Plan participants eligible for LTD coverage under the Plan will be provided with Aetna's Certificate of Coverage that describes in more detail the LTD benefits insured by Aetna. If you have any questions regarding LTD benefits insured by Aetna, how to file a claim, or Aetna's claims review and appeals procedures, please refer to Aetna's Certificate of Coverage, or call Aetna at 1-866-825-0186. You should keep the Certificate of Coverage with your Summary Plan Description (SPD) for future reference. If there is any conflict between the SPD and the Certificate of Coverage or any other insurance document provided by Aetna, the Certificate of Coverage and/or insurance documents control. If you need a copy of the Certificate of Coverage, you can contact Aetna at the number above, or you can contact the Benefits Service Center at 1-800-UPS-1508.

#### **New or Recurring Disabilities Arising Prior to January 1, 2013**

MetLife will continue to insure LTD benefits with respect to new disabilities that arise prior to January 1, 2013 (including any recurring disabilities associated with a disability that arose prior to January 1, 2013). See your SPD for MetLife's contact information. As noted in your SPD, MetLife insures the benefits pursuant to insurance documents provided by MetLife. If there is a conflict between those insurance documents and the SPD, the insurance documents control.

### **Long-Term Care**

In November 2010, MetLife made the decision to discontinue offering the long-term care insurance (LTC) product to new entrants after December 31, 2012.

If you would like to enroll in the MetLife LTC program before the deadline, you must request your enrollment application no later than December 3, 2012. Your application must be **received**—not postmarked—by MetLife no later than January 2, 2013. This will allow ample time for you to complete and return your application.

If you currently have LTC, or choose to purchase it by the deadlines above, your coverage is guaranteed renewable by MetLife as long as you continue making premium payments. MetLife will ensure that you continue to receive the same high level of service that you have come to expect.

LTC is subject to rate increases as determined by MetLife. It is not a UPS-administered health care plan and is only available as a voluntary benefit offering.



The long term care benefits are offered pursuant to insurance documents issued by MetLife. If there is any conflict between the insurance documents and the information contained in The Flexible Benefits Plan Summary Plan Description (including this SMM), the insurance documents control.

For more information on LTC, contact MetLife at 1-800-GET-MET8, or visit MetLife's website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

### **Spending Accounts**

#### **Health Care Spending Account (HCSA) and Limited Purpose Spending Accounts (LPSA)**

As part of the continued implementation of the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform," beginning January 1, 2013, the maximum employee contribution amount that you may elect to make during the Plan year to contribute to the Health Care Spending Account and the Limited Purpose Spending Account is \$2,500.

If you elect to participate in an HCSA or LPSA, then lose eligibility (for example, you terminate employment) and later become eligible again for this Plan or any other UPS-administered plan during the same year, the maximum employee contribution amount that you will be able to elect for the remainder of the year will be reduced by the total contributions you had already made during the same year. For example, if you elected \$2,500 for the year beginning January 1, 2013 and you terminate employment on March 31, 2013 after having contributed only \$208, the \$2,500 maximum employee contribution you can elect for 2013 will be reduced by the \$208 that you already contributed, to \$2,292 for the remainder of 2013.

#### **Health Savings Account (HSA)**

The maximum allowable annual contribution employees may make to their HSA will be \$3,250 for individual coverage or \$6,450 for family coverage.

The maximum allowable HSA catch-up contribution for individuals age 55 and older remains at an additional \$1,000 per year.

#### **Filing a Medical Claim**

*The following language is a clarification of current Plan administration.*

Any reimbursement checks that are not cashed within 12 months from the date of the check are void, and you lose any rights to such reimbursement.

#### **Behavioral Health Benefits**

*The following language is a clarification of current Plan administration of out-of-network facility claims*

*for behavioral health benefits. All other provisions of your behavioral health benefits remain unchanged.*

If you choose to seek treatment outside the ValueOptions network, the facility or treatment center must meet the following criteria to be eligible for coverage under the Plan:

- Possess all valid and applicable state licenses
- Possess the minimum level of professional liability coverage required by law
- Meet acceptable criteria for malpractice claims history for the past five years
- Possess a Drug Enforcement Administration (DEA) certification, if applicable
- Maintain accreditation from one of the following accrediting bodies:
  - National Committee for Quality Assurance (NCQA)
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - American Osteopathic Association (AOA)
  - Healthcare Facilities Accreditation Program (HFAP)
  - Accreditation for Ambulatory Health Care (AAAHHC)
  - Det Norske Veritas (DNV)
  - Community Health Accreditation Program (CHAP)

**Facilities such as therapeutic boarding schools and wilderness treatment programs often do not meet the criteria listed above and cannot be covered.**

For program specific criteria, contact ValueOptions at 1-800-336-9117 to obtain detailed coverage information.

#### **Medical Benefits**

All services performed or directed by a licensed chiropractor are covered at the applicable deductible and/or coinsurance level. Chiropractor visits, including office visits, manipulation(s), physical therapy and/or other related services, are limited to 40 visits per calendar year. Medical necessity review is not required. Services are covered for in-network providers only. Services from out-of-network chiropractic providers will not be covered.

#### **Critical Illness Insurance (CII)**

As of January 2012, MetLife now offers the Guarantee Issue benefit up to a \$15,000 benefit, with no waiting period. The Guarantee Issue benefit is described in more detail in the Certificate issued by

MetLife, which you can obtain by calling MetLife at 1-800-GET-MET8.

A new wellness screening benefit has been added to the policy. If you undergo one of the specified screenings outlined in the Certificate while you are covered under the policy and after your critical illness insurance has been in effect for 12 months, you will become eligible for a wellness screening benefit of up to \$75 per covered person each year. In order to receive the wellness screening benefit, you must submit to MetLife, at your expense, adequate evidence that the screening was performed. Such evidence must consist of written documentation satisfactory to MetLife that a covered person has undergone one of the screenings.

The policy pays only one screening benefit per covered person per calendar year.

All benefits are subject to the limitations and exclusions described in the Certificate. If there is a conflict between this summary and the Certificate, the Certificate controls. If you have any questions, contact MetLife at 1-800-GET-MET8.

#### **Grandfathered Plan Status**

The medical plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your Plan may not include certain consumer protections of PPACA that apply to other plans; for example, the

requirement to provide preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA; for example, the elimination of lifetime limits on essential health benefits (as defined by PPACA).

Questions regarding which protections apply and which do not apply to cause a plan to change from grandfathered health plan status can be directed to the Plan administrator at 1-800-UPS-1508. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

#### **Women's Health Rights**

The Women's Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of all stages of a mastectomy, including lymphedemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

# Summary of Material Modifications

## The Flexible Benefits Plan

### September 2011



*This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2012, unless otherwise noted. You should keep this with your Flexible Benefits Plan Summary Plan Description for future reference.*

#### Summary of Benefits: Medical Benefits

*The following is a summary of your benefits for a medically necessary visit to an urgent care clinic. The benefits listed below clarify current Plan administration and are subject to additional Plan limits, as described in the specific benefit plan sections of The Flexible Benefits Plan Summary Plan Description. All out-of-network and out-of-area medically necessary services are subject to reasonable and customary (R&C) limits.*

	Traditional Medical Option			Healthy Savings Medical Option		
	In-Network	Out-of-Network	Out-of-Area	In-Network	Out-of-Network	Out-of-Area
<b>Hospital Facility Charges</b>						
Urgent care clinic visit	85%	65%	85%	80%	60%	80%

#### Income Protection Plan: Short-Term Disability

*The following is a clarification of current Plan administration for short-term disability (STD) benefits under the Income Protection Plan.*

- STD benefits are offset by receipt of any of the following:
  - Discretionary days (such as sick pay or optional holiday pay, if applicable)
  - Holiday pay
  - Vacation pay
- Employees can elect to receive vacation pay with no offset between weeks 14–26 of STD leave if the sum of STD benefits and vacation pay does not exceed 100 percent of pre-disability weekly earnings.
  - Management and Specialist employees can use one day of vacation per week, between weeks 14–26, with no offset.
  - Administrative and Technical employees can use two days of vacation per week, between weeks 14–26, with no offset.
- Discretionary, holiday or vacation days taken during STD leave do not extend the maximum 26-week STD period.
- STD benefits paid by Aetna are computed using an average daily amount based on your annual base compensation.

#### Income Protection Plan: Long-Term Disability

##### LTD Exclusions and Limitations

*The following provisions of the long-term disability (LTD) benefits under the Income Protection Plan are no longer in effect. All other LTD exclusions and limitations remain unchanged.*

If your annual base compensation exceeds \$245,000 per year, you may be eligible for additional LTD benefits under the UPS Coordinating Benefit Plan.

##### Health Care Coverage and the Income Protection Plan

*The following is a clarification of current Plan administration in the event you become eligible for, and enroll in, coverage under the Retired Employees' Health Care Plan following the end of your 12-month extension of health care coverage.*

You remain eligible to continue coverage under the Retired Employees' Health Care Plan as long as you:

- Continue to be eligible and approved for LTD benefits by the claims administrator, and
- Are under age 65.

##### Quit For Life Tobacco Cessation Program

The Quit For Life vendor has changed its name from Free & Clear® to Alere Wellbeing™. You can contact them by calling 1-866-QUIT-4-LIFE (1-866-784-8454) or online at [www.quitnow.net/ups](http://www.quitnow.net/ups).

### Dental Benefits

Due to a typographical error, the following services were listed as covered under Preventive Services. The correct benefit for each service, as currently administered by the Plan, is covered under Basic Services:

- Scaling and root planing (four separate quadrants every two years)
- Gingivectomy (one per quadrant/site every three years)
- Osseous surgery (one per quadrant/site every three years)
- Occlusal guards (one every three years)
- Problem-focused exams (two per year)

You are responsible for the balance billed, including applicable deductible or amount that exceeds the reasonable and customary charge.

### Women's Health Rights

The Women's Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses, and
  - Treatment of physical complications of all stages of a mastectomy, including lymphedemas.
- Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

### Privacy Notice

Federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require health plans and health plan providers to protect the privacy of certain health information, while allowing the flow of information needed to provide high-quality health care. UPS has provided employees covered under a UPS-administered health care plan with a privacy notice describing the permissible uses and disclosures of health plan information.

To obtain a copy of that notice, you can:

- Visit [www.upshealthyconnections-informedchoices.com](http://www.upshealthyconnections-informedchoices.com) and click the Privacy link at the bottom of each page of the site;
- Log on to [www.UPSers.com](http://www.UPSers.com) and find your health care benefits information under the My Life and Career tab; or
- Call the UPS Benefits Service Center toll-free at 1-800-UPS-1508.

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This notice is intended to fulfill UPS's legal obligation to notify employees of material changes to The Flexible Benefits Plan. This notice formally amends the coverage available under the Plan.

## Summary of Material Modifications

### The Flexible Benefits Plan

May 2011



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*This notice details Plan improvements, changes, clarifications, and required notifications effective June 1, 2011, unless otherwise noted. These provisions do not apply to ConnectShip employees, or employees on disability leave prior to June 1, 2011. You should keep this with your Flexible Benefits Plan Summary Plan Description for future reference.*

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#### **Income Protection Plan: Short-Term Disability**

*The following provisions of the short-term disability (STD) benefits under the Income Protection Plan are effective June 1, 2011. All other provisions of the Income Protection Plan remain unchanged.*

If you qualify for STD benefits, you are paid a percentage of your base pay for up to 26 weeks.

If you are a Management or Specialist employee, you will receive your paycheck from the Company, including your usual payroll deductions, through the end of the pay cycle in which your disability leave begins.

Aetna Disability and Absence Management (ADAM) will administer your STD payment beginning the first day of the pay cycle following your last day worked.

Approved benefits will be paid by ADAM on a weekly schedule. If you are a Management employee, you must contact ADAM on the first day of your disability to ensure that there is no interruption in receiving your paycheck from ADAM.

In any case, your claim must be received (via phone or Web) within 60 days of the initial date of your disability in order for you to receive STD benefits.

STD benefits are taxed when paid to you. ADAM will issue W-2 forms for any benefits you receive under the STD Plan.

You will be billed by the Benefits Service Center for your share of the cost of your Flexible Benefits Plan coverage. If you fail to make timely payments of this bill, your coverage will be terminated.

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This notice is intended to fulfill UPS's legal obligation to notify employees of material changes to The Flexible Benefits Plan. This notice formally amends the coverage available under the Plan.



## Summary of Material Modifications

### The Flexible Benefits Plan

December 2010

*This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2011, unless otherwise noted. It has been revised from its original December 2010 printing to accurately reflect changes to ConnectShip employees. You should keep this with your Flexible Benefits Plan Summary Plan Description for future reference.*

#### **Income Protection Plan: Short-Term Disability**

*The following provisions of the short-term disability (STD) benefits under the Income Protection Plan are effective January 1, 2011. All other provisions of the Income Protection Plan remain unchanged.*

##### **STD Coverage**

If you qualify for STD benefits, you are paid a percentage of your base pay for up to 26 weeks.

If you are an Administrative or Technical employee, the calculation used to determine your average, weekly base pay, as described in your Summary Plan Description (SPD) and SPD insert, remains unchanged.

If you are a Management or Specialist employee, the Plan pays 100 percent of your base pay for the first 13 weeks, and then 80 percent of your base pay for the remaining 13 weeks of approved STD.\*

*\*The provisions in this paragraph do not apply to ConnectShip employees.*

##### **STD Exclusions and Limitations**

Receiving vacation pay does not preclude you from receiving STD benefits or extend your disability period.

##### **If You Have More Than One STD Absence**

If you are on an approved disability on January 1, 2011, and subsequently return to work (other than as a participant in a residual disability/return-to-work program, you are subject to the following return-to-work provisions.

If you are absent and receiving STD benefits and return to work for less than 30 consecutive calendar days (other than as a participant in a residual disability/return-to-work program), your second absence will be considered a continuation of the first disability period and both periods of absence count toward the 26-week period of STD benefits.

If you are absent and receiving STD benefits and return to work for at least 30 consecutive calendar days (other than as a participant in a residual disability/return-to-work program), you are eligible for a new 26-week period of STD benefits. You must have returned to work for at least 30 consecutive calendar days to be eligible for a new 26

weeks of STD. Otherwise, your second absence will be considered a continuation of the first disability period and both periods of absence count toward the 26-week period of STD benefits. This provision applies regardless of whether the subsequent disability is due to the same or a different cause.

Vacation or discretionary days are not counted in determining whether you have returned to work for 30 consecutive calendar days.

##### **STD Benefit Offsets**

If you return to work after the first 13 weeks of STD benefits, your STD benefit will not be offset by any residual disability/return-to-work amounts that you earn until your return-to-work earnings exceed 20 percent of your pre-disability base pay.

##### **Dependent Children Under Age 26**

The September 2010 SMM explained that an otherwise eligible child is not eligible for coverage under this Plan if the child is eligible for coverage under another employer-sponsored plan. This provision applies to any coverage under this Plan, including medical, dental and vision. A child cannot be added to any coverage under this Plan if the child is eligible for medical coverage from his or her own employer-sponsored plan.

##### **HIPAA Certificate of Creditable Coverage**

A Certificate of Creditable Coverage shows the dates coverage begins and ends under a health care plan. It is used if you are leaving UPS and obtaining coverage from another source that has a pre-existing condition exclusion. If you provide your new plan with a Certificate of Creditable Coverage within 63 days of the date your UPS coverage ends, your new plan cannot enforce any pre-existing condition exclusions it may otherwise contain.

UPS automatically sends Certificates of Creditable Coverage with COBRA notices. If you need a Certificate of Creditable Coverage in advance of receiving a COBRA notice, please call the UPS Benefits Service Center at 1-800-UPS-1508.

## Prescription Drug Benefits

*The following content clarifies current Plan administration.*

### Out-of-Pocket Coinsurance

A per-script coinsurance minimum and maximum out-of-pocket applies to most prescriptions. This is the minimum and maximum coinsurance amount you are required to pay out-of-pocket for a covered prescription drug:

- If the cost of the drug is less than the minimum, you pay the full cost of the drug
- If the amount of your coinsurance is the same or less than the minimum, you must pay the minimum amount
- If the amount of your coinsurance is greater than the maximum, you pay only the maximum amount

*The following content reflects a change in your prescription drug benefits.*

### Brand-to-Generic Difference

If you purchase a brand-name drug when a generic is available, you must pay the difference in cost between the brand and generic drug, up to the non-preferred per-script maximum amount, in addition to your coinsurance amount. This difference is **not** included in the per-script coinsurance maximum out-of-pocket or your annual out-of-pocket maximum.

**Example:** You purchase, from a retail pharmacy, a non-preferred brand drug priced at \$5,000, even though a generic drug is available for \$300. The Plan pays \$240, which is 80% of the cost of the generic drug. Your coinsurance is 20%, or \$60, which is within the per-script minimum and maximum amounts for a generic drug from a retail pharmacy. You must pay \$60 plus the difference between the price of the brand and generic drugs, **up to the non-preferred maximum amount**, which is \$300 from a retail pharmacy. Your total cost is \$360.

Prior to this change, you would have paid the \$60 coinsurance plus the entire \$4,700 difference between the price of the brand and generic drugs, for a total of \$4,760.

## Summary of Benefits

### Prescription Drug Benefits

*The following content reflects a change in your prescription drug benefits.*

	Traditional Option	Healthy Savings Option	Retail Pharmacy Per-Script Min/Max*	Medco By Mail Per-Script Min/Max*
Generics	80%	80% after deductible; deductible waived if preventive care med.	\$5/\$100	\$10/\$200
Preferred brands**	80%	80% after deductible; deductible waived if preventive care med.	\$25/\$150	\$50/300
Non-preferred brands** and non-sedating antihistamines	50%	50% after deductible; deductible waived if preventive care med.	\$50/\$300	\$100/\$600

*\*The per-script coinsurance minimum/maximum applies to both the Traditional and Healthy Savings medical options. In the Healthy Savings option, the per-script coinsurance minimum and maximum applies only after the annual deductible has been met or if the drug is considered a preventive care medication. Until the annual deductible for this medical option has been met, you are responsible for the entire cost of the prescription.*

*\*\*If you purchase a brand-name drug when a generic is available, you must pay the difference in cost between the brand and generic drug, up to the non-preferred per-script maximum amount, in addition to your coinsurance amount. This difference is not included in the per-script coinsurance maximum out-of-pocket or your annual out-of-pocket maximum.*

This notice is intended to fulfill UPS's legal obligation to notify employees of material changes to The Flexible Benefits Plan. This notice formally amends the coverage available under the Plan.

## Summary of Material Modifications

### The Flexible Benefits Plan

September 2010



*This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2011, unless otherwise noted. You should keep this with your Flexible Benefits Plan Summary Plan Description for future reference.*

#### Health Care Reform

In March, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), also known as "health care reform." Effective January 1, 2011, PPACA requires the following changes to your UPS-administered health care plan. If the PPACA provisions requiring these Plan changes are ever repealed, the changes made solely as a result of PPACA will be terminated and the provisions of the Plan modified by PPACA will be reinstated effective the date the law is repealed.

#### Grandfather Plan Status

UPS believes this Plan is a "grandfathered health plan" as defined under PPACA. A grandfathered health plan is permitted to preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections included in PPACA which apply to other plans that are not grandfathered plans. For example, the requirement to provide preventive health services without any cost sharing does not apply to a grandfathered health plan such as your Plan. However, grandfathered health plans are not exempt from all consumer protections included in PPACA. For example, PPACA's prohibition against lifetime limits on "essential benefits" does apply to grandfathered health plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator identified in the Summary Plan Description (SPD). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This Web site has a table summarizing protections under PPACA, and which do and do not apply to grandfathered health plans.

#### Dependent Children Under Age 26

You may now cover a "Child" through the end of the month in which the child turns age 26. A "Child" is defined as your natural child, your adopted child, a child

placed with you for adoption, or a child for whom you are the legal guardian (as determined in accordance with applicable law).

If you have a "Child" who previously lost coverage under your Plan, was denied coverage, or was otherwise not eligible for coverage under your Plan because he or she did not satisfy your Plan's prior definition of dependent child (for example, your child turned age 19 but was not a full-time student), you will have 30 days, beginning the first day of the annual enrollment period, to enroll yourself (if eligible but not enrolled) and/or your child in the Plan. If you enroll your child during the 30-day enrollment period, coverage for your child will be effective on January 1, 2011 (provided that the individual is a child on January 1, 2011). Notwithstanding anything to the contrary, an otherwise eligible child is not eligible for coverage under this Plan if the child is eligible for coverage under another employer-sponsored plan (other than the parent's employer-sponsored plan—keep in mind that the child could be eligible for the parent's employer-sponsored plan as both a dependent and an employee).

A covered child who becomes incapacitated while covered under the Plan and before he or she turns age 26 is eligible to continue coverage after turning age 26 as long as you are eligible and as long as the following conditions are satisfied: (i) the incapacity exists, (ii) the child is unmarried, (iii) the child is primarily dependent on you for support and maintenance, and (iv) appropriate certification of disability is provided. You must apply to continue coverage for an incapacitated dependent prior to age 26.

The child must have a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator. To apply for continuation of coverage for an incapacitated dependent, contact your claims administrator. Certification of the incapacitation by the claims administrator must occur prior to coverage being continued under the Plan. Certification must also occur before coverage is lost under the Plan. In addition, periodic medical documentation of the continuing incapacity is required as determined by the claims administrator.



In addition, the following benefits previously provided only to children under age 19 are revised as follows:

- Charges for hearing exams and one hearing aid per ear every three years for children up to age 26 (must be prescribed by an otolaryngologist).
- Benefits are allowed for teeth straightening for your dependent children under 26 years of age. Services provided by the end of the month in which your child turns 26 are covered, as long as treatment began before the child's 26th birthday.

#### **Elimination of Lifetime Maximum Benefits**

Lifetime dollar limits on aggregate benefits will be eliminated from your Plan effective January 1, 2011. If you are an otherwise eligible employee whose coverage previously ended upon reaching your lifetime maximum benefit under the Plan, you will have 30 days, beginning the first day of the annual enrollment period, to re-enroll in the Plan. If you choose to enroll, your coverage is effective January 1, 2011 (as long as you continue to meet the Plan's eligibility requirements). You may also enroll any dependents whose coverage ended upon reaching their lifetime maximum.

#### **Elimination of Lifetime and Annual Dollar Limits for "Essential Benefits"**

Effective January 1, 2011, lifetime and annual dollar limits on essential benefits will be administered in accordance with PPACA. This means the dollar maximums on the following "essential benefit" will be eliminated:

- Lifetime limit on outpatient hospice care

#### **Elimination of Pre-existing Conditions on Benefits for Children Under Age 19**

Pre-existing condition limits will be eliminated from your Plan effective January 1, 2011, for children under age 19. The following are considered by PPACA to be the only pre-existing conditions under the Plan. All language in the SPD will otherwise continue to be administered based on the terms and intent of the Plan, with only the pre-existing condition exclusions removed in the following provisions for children under age 19:

- Cosmetic/plastic surgery needed to correct a malformation as a direct result of disease, surgery performed to treat a disease, or an accidental injury that occurred prior to coverage under the Plan is not covered.
- Dentures and bridgework for replacement of teeth extracted before the patient was covered by a UPS dental option are not covered.
- Orthodontia treatment already in progress prior to becoming covered under the Plan is not covered.
- Replacement of congenitally missing teeth is not covered.

#### **HCSA or HSA Reimbursement of Over-the-Counter Drugs**

Any expenses incurred on or after January 1, 2011 for over-the-counter (OTC) medicines or drugs (with the exception of insulin) will be eligible for reimbursement from a Flexible Spending Account such as your health care savings account (HCSA), or a Health Savings Account (HSA) only if the medications are prescribed by a physician. The terms "medicines or drugs" and "prescribed" will be defined in accordance with applicable IRS regulations.

#### **Mental Health Parity**

Effective January 1, 2011, the administration of your behavioral health coverage will be amended per the federal regulations set forth in the Mental Health Parity and Addiction Equity Act.

#### **Precertification Requirements**

ValueOptions must always precertify the following services, regardless of whether an in- or out-of-network provider or facility is used. If you fail to have these services approved in advance, no benefits are payable.

- Psychological testing
- Complex medication management
- Electroconvulsive therapy (ECT)
- Biofeedback
- Hypnotherapy
- Aversion therapy

There is no precertification requirement for in- or out-of-network inpatient or outpatient treatment. However, all treatment must be determined, by ValueOptions, to be medically necessary.

To ensure you receive the maximum benefits under the Plan, you should always contact ValueOptions at 1-800-336-9117 prior to seeking any mental health or substance abuse treatment.

Mental health parity legislation does not affect the Solutions – Your EAP and Work/Life Benefit program, also administered by ValueOptions. You are eligible to receive six free in-person visits (per issue, per year) with a licensed, in-network Employee Assistance Program provider, as well as referrals for legal, financial and work/life resources. Refer to your SPD or contact ValueOptions at 1-800-336-9117 for program details.

#### **Health Savings Account (HSA) Penalty Increase**

If an employee is under age 65 and enrolled in an HSA, any funds withdrawn from that account that are not used for qualified health care expenses will be subject to a 20 percent tax penalty, which is an increase from the current 10 percent penalty.

#### **Network Carrier Changes**

The Dental DMO will no longer be offered in Louisiana effective January 1, 2011. Please refer to your annual

enrollment materials for the dental options available to you for 2011. Participants currently enrolled in the DMO who do not choose another dental option for 2011 will be enrolled in Dental Option 1, which is a Dental PPO offered by Aetna and has an 80% coinsurance benefit.

### **Transferring from the Flexible Benefits Plan**

If you're a current employee transferring from The Flexible Benefits Plan to another UPS-administered plan but your effective date is delayed until you reach your seniority attainment date (SAD), The Flexible Benefits Plan will provide certain types of coverage during the waiting period. As a clarification of current Plan administration, this coverage includes any elected tax-advantaged accounts. Your current elections, as well as applicable payroll deductions, will continue during the waiting period.

### **Hyatt Legal Plan**

The Hyatt Legal Plan will offer the following new services:

- **Adoption and Legitimization (Contested and Uncontested).** This service covers all legal services and court work in a state or federal court for an adoption by the legal plan member and spouse. Legitimization of a child by the legal plan member and spouse, including reformation of a birth certificate, is also covered. This includes international adoptions.
- **Security Deposit Assistance.** This service covers counseling the participant as a tenant in recovering a security deposit from the participant's residential landlord for the participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the participant for the small claims trial. This service does not include the legal plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

### **MetLife Critical Illness Plan**

As of August 31, 2010, participants in the MetLife Critical Illness Insurance (CII) fully underwritten plan will be transitioned to an enhanced MetLife CII fully underwritten plan. During the UPS annual enrollment for 2011 benefits, current participants in the MetLife CII plan will be automatically enrolled into the new and enhanced fully underwritten CII plan. You will have the option to keep or cancel your current CII plan by notifying MetLife at 1-800-GET-MET8.

Under this new offer, you or your covered dependent can receive a lump-sum benefit payment if you experience a

covered condition in one of three distinct categories (as defined in the group certificate):

- **Category 1** incorporates certain cancer-related conditions: Full Benefit Cancer, Partial Benefit Cancer and Bone Marrow Transplant. (For some types of cancer and a coronary artery bypass graft, you will receive 25% of the category benefit amount.)
- **Category 2** incorporates certain heart-related conditions: Heart Attack, Heart Transplant, Stroke (in certain states, the covered condition is severe stroke) and Coronary Artery Bypass Graft.
- **Category 3** incorporates certain other covered conditions: Major Organ Transplant (other than bone marrow and heart) and Kidney Failure.

Coverage amounts for the Simplified Issue CII benefit will be available for the employee, spouse or domestic partner, and children in the benefit amount of \$10,000 for each category, regardless of whether you currently participate in the fully underwritten CII plan.

For more questions about the program, visit the MetLife Web site at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) or contact a MetLife CII Customer Service Representative at 1-800-GET MET 8 (1-800-438-6388).

As with any benefit offered under your Plan that is insured by an insurance carrier pursuant to an insurance contract, the terms of the insurance control if there is a conflict between this summary and the insurance contract (including any certificates of coverage provided by the insurance carrier).

### **Long-Term Care Insurance**

Long-term care insurance rates increased effective August 1, 2010. This rate increase applies only to new applicants. If you enrolled in the long-term care insurance under the Plan prior to August 1, 2010, your rates will remain the same. Refer to your rate sheet from MetLife for more information.

### **Women's Health Rights**

The Women's Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

Reconstruction of the breast on which the mastectomy was performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

## Privacy Notice

Federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require health plans and health plan providers to protect the privacy of certain health information, while allowing the flow of information needed to provide high-quality health care. UPS has provided employees covered under a UPS-administered health care plan with a privacy notice describing the permissible uses and disclosures of health plan information.

To obtain a copy of that notice, you can:

- Visit [www.upshealthyconnections-informedchoices.com](http://www.upshealthyconnections-informedchoices.com) and click the Privacy link at the bottom of each page of the site;
- Log on to [www.UPSers.com](http://www.UPSers.com) and find your health care benefits information under the My Life and Career tab; or
- Call the UPS Benefits Service Center toll-free at 1-800-UPS-1508.

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This notice is intended to fulfill UPS's legal obligation to notify employees of material changes to The Flexible Benefits Plan. This notice formally amends the coverage available under the Plan.

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## Overview of the Plan

Concern for the security and well-being of you and your family is the cornerstone of the UPS benefits philosophy. We regard our benefits expenditures as an investment in your health and security.

This book describes provisions of The Flexible Benefits Plan. The Plan is designed to ensure that you receive value for the benefit dollars spent. The Plan is one of the many pay and benefit programs provided by UPS, known collectively as your total rewards.

The Plan offers you the opportunity to elect a variety of benefit choices, allowing you to customize your benefits package to meet your own unique needs. Because your needs will change over time, you can elect new benefits annually.

Additional important information about your coverage is described in your Flexible Benefits Plan Summary Plan Description (SPD) insert. Keep your insert with this booklet for reference.

### Basic Benefits

These basic benefits are automatically provided to participants in The Flexible Benefits Plan:

- Medical and behavioral health
- Prescription drug
- Dental
- Vision
- Basic life insurance for you\*
- Basic life insurance for your eligible spouse and children\*
- Basic accidental death and dismemberment (AD&D) insurance for you\*
- Short-term disability
- Long-term disability income (full-time employees only)
- Employee assistance program (EAP) and work/life benefit
- Adoption assistance program
- Tobacco cessation program

### Supplemental Benefits

Employees eligible for The Flexible Benefits Plan may also elect and pay for the following types of supplemental coverage:

- Supplemental life insurance for you\*
- Supplemental life insurance for your spouse and/or children\*
- Supplemental AD&D coverage for you and your family\*
- Personal lines of insurance\*\*
- Tax-advantaged reimbursement accounts:
  - Health Care Spending Account (HCSA)
  - Limited Purpose Spending Account (LPSA)
  - Child/Elder Care Spending Account (C/ECSA)
- Critical illness insurance\*
- Long-term care insurance\*
- Legal assistance\*

In addition, if you enroll in the Healthy Savings medical option and you meet other eligibility requirements described in the Internal Revenue Code, you may establish and make contributions to a health savings account (HSA). If you establish an HSA with OptumHealth Bank, your HSA contributions may be made with pre-tax payroll deductions. The HSA is not sponsored or maintained by UPS — it is a personal account. Nor is the HSA part of The Flexible Benefits Plan, even though you may contribute to your HSA established with OptumHealth Bank with pre-tax payroll deductions.

*\*Although these benefits are described in this booklet and are part of The Flexible Benefits Plan, they are not intended to be nor should they be construed to be part of the pre-tax cafeteria plan.*

*\*\*Although communicated in this booklet, personal lines of insurance is not a part of The Flexible Benefits Plan.*

## How the Plan Works

The key to The Flexible Benefits Plan is choice, and that's important because everyone has a different lifestyle and different benefit needs. That's why the Plan offers two PPO network options and your choice of many supplemental benefits. Depending on your choices and the benefit options you select, you may or may not have to make a contribution for coverage.

You can change your benefit choices each year during the annual enrollment period

(with certain exceptions — as described later in this booklet — for dental, vision and long-term disability income). The benefits you elect at that time will be effective for the following calendar year.

You can change your benefit elections during the year only if you experience a “life event,” such as marriage, birth of a baby or adoption, or divorce. See the *Life Events* section for more information about life events that qualify for mid-year benefits changes.

## Coverage Categories (Who is Covered)

<i>Type of Coverage</i>	<i>Coverage Categories</i>	<i>Comments</i>
<ul style="list-style-type: none"> <li>• Medical (including behavioral health and prescription drug benefits)</li> <li>• Dental</li> <li>• Vision</li> </ul>	<ul style="list-style-type: none"> <li>• You only</li> <li>• You plus spouse</li> <li>• You plus children</li> <li>• You plus family</li> <li>• Opt out</li> </ul>	You select one of these options. To opt-out, you must certify you have medical coverage elsewhere
<ul style="list-style-type: none"> <li>• Basic life insurance</li> </ul>	You, your spouse and your dependent children	Provided for all enrolled participants at no additional cost to you
<ul style="list-style-type: none"> <li>• Basic AD&amp;D</li> </ul>	You only	Provided at no additional cost to you
<ul style="list-style-type: none"> <li>• Supplemental life insurance and AD&amp;D</li> </ul>	Refer to the Prudential® Enrollment Kit for details	Available at additional cost to you. Refer to the Prudential Enrollment Kit for details
<ul style="list-style-type: none"> <li>• Short-term disability (STD)</li> <li>• Long-term disability (LTD)</li> </ul>	You only	LTD is available to full-time employees only, and you may be required to pay a portion of the cost. STD is provided at no additional cost to you.
<ul style="list-style-type: none"> <li>• EAP and work/life</li> <li>• Tobacco cessation</li> <li>• Tax-advantaged reimbursement accounts (HCSA, LPSA and C/ECSA)</li> <li>• Legal plan</li> <li>• Critical illness insurance</li> <li>• Long-term care insurance</li> <li>• Adoption assistance</li> <li>• Personal lines of insurance</li> </ul>	See the related sections of this booklet for details	Some of these benefits are available at additional cost to you.

## Overview of the Plan (cont.)

### Taxes and Your Benefits

One of the advantages of the Plan is that it contains an Internal Revenue Code Section 125 cafeteria plan component. This means you can pay your portion, if any, of the cost of many benefits with pre-tax payroll deductions.

The following table shows which benefits are paid for before taxes are withheld (which means they are part of the cafeteria plan), and which are paid after taxes (which means they are not part of the cafeteria plan).

Contributions to a health savings account (HSA) established with OptumHealth Bank are paid before taxes but are not part of the cafeteria plan.

#### ***Paid for Before Taxes***

- Contributions for medical (including behavioral health and prescription drug), dental and vision coverage
- Tax-advantaged reimbursement accounts (HCSA, LPSA and C/ECSA)
- Long-term disability

#### ***Paid for After Taxes***

- Employee's supplemental life insurance
- Spouse's supplemental life insurance
- Children's supplemental life insurance
- Employee's supplemental AD&D coverage
- Legal assistance
- Critical illness insurance
- Personal lines of insurance
- Long-term care insurance

### Paying for Benefits

UPS typically makes a contribution toward the cost of your health care and your long-term disability (LTD) premium. UPS's contributions, if any, for the benefit options are identified each year in your enrollment materials. You choose the benefits coverage that best meets your needs.

### Glossary of Benefit Terms

The following terms are used throughout this booklet to explain how your benefits work. More specific information appears in the related sections, and controls.

<b>Annual deductible</b>	The amount you must pay out of pocket for covered services in a calendar year before the Plan begins to pay benefits for covered services. In some cases — specifically for some preventive care — the deductible is not applied. The amount of the annual deductible varies with the option you select. The annual deductible begins accumulating at zero on January 1 each year — there is no carryover from the previous year.
<b>Annual out-of-pocket maximum</b>	The maximum amount you are responsible to pay for covered health care expenses in a calendar year. When your eligible out-of-pocket expenses reach the annual out-of-pocket maximum in a calendar year, the Plan pays 100 percent of most covered charges for the rest of that year. Eligible out-of-pocket expenses accumulated toward the annual out-of-pocket maximum include deductibles (if applicable) and coinsurance amounts. Out-of-pocket expenses <b>not</b> accumulated toward the annual out-of-pocket maximum include any amounts over the reasonable and customary (R&C) limit and expenses not covered by the Plan.
<b>Claims Administrator</b>	The company that administers health care benefits and is responsible for processing claims for those benefits.
<b>Coinsurance</b>	The percentage of covered services the Plan or the employee pays after you have met the annual deductible. For example, for an in-network office visit, the Plan pays 80 percent if you are covered under the Healthy Savings medical option, and you pay 20 percent. In all cases, the coinsurance may be different for in-network and out-of-network services.

## Glossary of Benefit Terms (cont.)

<b>Emergency</b>	An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or the unborn child in the case of a pregnant woman) in serious jeopardy.
<b>Investigational or experimental</b>	Describes a health care service or supply for which the medical use is still under study and not yet formally recognized throughout the medical profession in the U.S. as safe and effective.
<b>Lifetime maximum benefits</b>	<p>The total amount of medical, behavioral health, and prescription drug benefits payable to an individual over his or her lifetime under the Plan, regardless of whether you choose the Traditional or Healthy Savings medical option. If you switch options, benefits provided under the prior option(s) are counted toward your lifetime maximum under the new option.</p> <p>However, once the lifetime maximum benefit has been paid, up to \$1,000 will be restored on January 1 each year thereafter, to provide a total of \$1,000 of payable benefits to that individual during that year. Also, amounts the Company recovers under the Plan's right of recovery provisions (except amounts recovered as a result of erroneous payments), are credited toward the lifetime maximum, reduced by the Plan's expenses incurred to recover the amount.</p>
<b>Medically necessary</b>	A criteria established by the claims administrator and includes, but is not limited to, their determination of required or necessary services, supplies and/or standards of care by using currently available clinical information. This information includes clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in clinical areas, and other relevant factors for the diagnosis, care or treatment of a disease, injury or illness (including pregnancy) within generally accepted medical practice.
<b>Network</b>	<p>A group of doctors, hospitals and other health care providers who have agreed to provide their services to participants at contracted rates. Here are some related terms:</p> <p><b>In-network</b> — Describes services provided by doctors, hospitals and other health providers who participate in the Plan's network. Also describes the level of benefits paid by the Plan (as shown in the <i>Summary of Benefits</i> section of this booklet) for services provided by in-network providers.</p> <p><b>Out-of-network</b> — Describes services rendered by health providers who <b>do not</b> participate in the Plan's network. Also describes the level of benefits paid by the Plan (as shown in the <i>Summary of Benefits</i> section) when services are rendered by out-of-network providers to participants who live within a network area.</p> <p><b>Out-of-area</b> — Describes services rendered by providers outside the Plan's network area. Also describes the level of benefits paid by the Plan (as shown in the <i>Summary of Benefits</i> section) when services are rendered by out-of-area providers to participants who live outside the network area and have not "opted in" during enrollment to the medical network designated for their home state.</p>
<b>Per-script minimum and maximum</b>	The minimum and maximum amount you are required to pay out-of-pocket for a covered prescription drug after the applicable coinsurance, R&C and brand-to-generic difference provisions are applied. If your coinsurance amount is less than the per-script minimum, you must pay the minimum amount; if your coinsurance amount exceeds the per-script maximum, you pay only the maximum amount and the Plan pays the difference.
<b>Preauthorization</b>	The process by which a patient is pre-approved for coverage of a specific medical, dental or behavioral health procedure or treatment. A claims administrator may require that patients meet certain criteria or that certain conditions be met before coverage is approved. In some cases, your doctor may be required to submit notes and/or lab results documenting your condition and treatment history.
<b>Preventive care</b>	Health care provided solely for the purpose of preventing an illness that has not yet been diagnosed, not to treat an illness or injury. The medical carriers carefully follow various guidelines for what is considered preventive care, such as those published by the U.S. Preventive Services Task Force, the American Medical Association, the American Academy of Pediatrics and the IRS.
<b>Prior authorization</b>	The process by which a patient is pre-approved for coverage of a specific prescription drug. A claims administrator may require that patients meet certain criteria or that certain conditions be met before coverage is approved. In some cases, your doctor may be required to submit notes and/or lab results documenting your condition and treatment history.
<b>Reasonable and customary (R&amp;C)</b>	Refers to charges within the normal range of fees in your geographic area for similar services or supplies, as determined by the claims administrator. Generally, when you receive services from out-of-network or out-of-area providers, you are responsible for paying the amount of the charges that exceed R&C limits. Also known as R&C.



## Same-Sex Domestic Partners or Civil Union Partners

*You may be eligible to elect certain benefits for either your same-sex domestic partner and his or her dependent children, or civil union partner and his or her dependent children.*

*Complete information about eligibility and what coverage is available for same-sex domestic partners, civil union partners and their dependent children is contained in separate documents. Visit [www.UPSers.com](http://www.UPSers.com) for a link to these documents, or call 1-800-UPS-1508 and listen for the "Health Care," then "Coverage Changes and Dependents" prompts to request either the Same-Sex Domestic Partner brochure or the Same-Sex Civil Union brochure.*

## Eligibility

As a union-free employee of UPS, you have the option to enroll in coverage for you and your eligible dependents in The Flexible Benefits Plan. This section defines eligibility in the Plan, and indicates when coverage begins and ends. You should refer to your Flexible Benefits Plan Summary Plan Description insert to determine whether additional eligibility requirements apply to you.

### Dependents Eligible for Coverage

It's important that you know exactly what "dependent" means for each type of coverage under The Flexible Benefits Plan.

The term "dependent" has the same meaning for medical, dental, vision, life insurance and the employee assistance program (EAP), as described in this section.

The definition of "dependent" is different for the tax-advantaged reimbursement accounts (HCSA, LPSA and C/ECSA). Other benefits, such as legal assistance, critical illness, long-term care insurance, and personal lines of insurance, may also define eligible dependents differently. Refer to those sections of this booklet for applicable dependent eligibility information.

### Proof of Dependent Status

The Plan Administrator may periodically request proof of dependent status. In addition, you may be required to provide certain information deemed necessary by the Plan Administrator as a condition of eligibility for you and/or your dependents. For example, you must provide a Social Security number (SSN) to the Benefits Service Center for each dependent you wish to enroll in the Plan to satisfy federal reporting requirements. This allows UPS to comply with a law requiring health plan administrators to electronically report data for covered plan participants to the Centers for Medicare and Medicaid Services (CMS).

Spouses, same-sex domestic partners and/or civil union partners are not eligible to begin coverage until an SSN has been provided as part of enrollment. Coverage for dependent children begins upon enrollment; however, if a child's SSN is not received by the due date indicated on the enrollment form, coverage for the child will be terminated retroactive to the date coverage began.

If you fail to provide the requested information or proof, coverage may be terminated or delayed for you and/or your dependents, and you may be required to reimburse the Plan for any expenses for which benefits were paid on behalf of an otherwise ineligible dependent. See *Right of Recovery* in the *Filing a Claim* section of this booklet for more information on the Plan's right to reimbursement.

### Eligibility for Medical, Dental, Vision, Life Insurance and EAP

You may enroll your dependents for coverage in The Flexible Benefits Plan if the dependent is one of the following. See the information that follows for additional clarification about some of the terms used below.

- Your legal spouse as defined by applicable state law
- An unmarried child who is:
  - A natural child; an adopted child (or a child placed with you for adoption); a stepchild living with you at least half of the time; a stepchild who is a full-time student away from home, provided that the stepchild lived with you at least one half of the time during the year immediately prior to the year the stepchild became a full-time student away from home; or a child for whom you are the court-appointed custodian or guardian; and

- Under age 19 and financially dependent on you, up to age 25 if a full-time student and still financially dependent on you, or an incapacitated child who satisfies the additional eligibility requirements described in this booklet.

### Spouse

If your spouse is your legal spouse under the common law of the state in which you reside, you will be required to provide evidence of the state's law and evidence that you meet the state requirements.

### Placed for Adoption

For The Flexible Benefits Plan, "placed with you for adoption" means that you have become legally obligated to support the soon-to-be-adopted child as a result of beginning the adoption process.

### Full-Time Student

A student is considered full time if he or she meets the requirements of full-time status for the school he or she attends. You must certify your child's student status each year during annual enrollment, or he or she will lose coverage for the following year. Your child may be eligible to temporarily continue his or her coverage under the Plan if he or she ceases to be a full-time student due to medical reasons. See the *What If...* section of this SPD for more details.

### Incapacitated Children

A covered incapacitated child is eligible to continue dependent coverage as long as the capacity exists, when all of the following criteria have been met:

- The child becomes incapacitated before age 19 (or before age 25 if a full-time student)
- The child becomes covered by the Plan prior to age 19 (or before age 25 if a full-time student)
- The child is unmarried and primarily dependent on you for support and maintenance, and
- Appropriate certification of the incapacitation has been provided

You must apply to continue coverage for an incapacitated dependent prior to age 19 (or before age 25 if a full-time student).

The child must have a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by claims administrator. To apply for continuation of coverage for an incapacitated dependent, contact your claims administrator. Certification of the incapacitation by the claims administrator must occur prior to coverage being continued under the Plan. Certification must also occur before coverage is lost under the Plan. In addition, periodic medical documentation of the continuing incapacity is required as determined by the claims administrator.

## Eligibility (cont.)

### ***When Spouses or Children Are Also UPSers***

If you and your spouse or child both work for UPS and are both eligible for The Flexible Benefits Plan, the following conditions apply:

- Each of you may elect employee coverage under the medical, dental and vision options. Only one spouse may elect coverage for your eligible children.
- Each of you can be covered only once under The Flexible Benefits Plan; you may not be covered as both an employee and a spouse or child of an employee. You may elect coverage for your spouse or child as your dependent, and your spouse or child may elect no coverage.
- You and your spouse or child may each elect employee life insurance as an employee\*. Only one spouse may elect life insurance coverage for your eligible children.

If you are eligible for The Flexible Benefits Plan and your spouse or child is covered by another UPS-sponsored plan (for example, UPS Health and Welfare Package) or a multi-employer health care plan to which UPS contributes:

- You may elect any available family coverage option.
- You may elect not to enroll in medical coverage under the Plan if you provide certification that you are covered elsewhere (for example, under your spouse's plan). This is known as "opting out." If you are eligible for any health plan that UPS administers or contributes to and do not elect medical coverage under The Flexible Benefits Plan, you will not receive any opt-out credits.

Even if you opt out of medical coverage, you may elect participation in other types of coverage under The Flexible Benefits Plan, including dental, vision, life insurance\*, AD&D coverage, legal assistance, tax-advantaged reimbursement accounts (HCSA, LPSA and C/ECSA) and personal lines of insurance.

- If you enroll your spouse or child as your dependent in The Flexible Benefits Plan, your spouse or child may also continue coverage as an employee through the other UPS-sponsored or multi-employer health care plan to which UPS contributes.

If you or your spouse or child is covered under two UPS-sponsored or related plans, see *Maintenance of Benefits* in the *Filing a Claim* section of this booklet for information about how the Plan pays benefits in this situation.

*\*If your spouse or child is eligible as an employee for supplemental life insurance through this Plan or another UPS-sponsored plan (for example, the UPS Health and Welfare Package), you are not eligible to cover your spouse or child for supplemental life insurance through The Flexible Benefits Plan. Your spouse or child must elect employee supplemental life insurance through his or her own employee plan.*

### ***Qualified Medical Child Support Orders (QMCSO)***

Medical (including behavioral health, prescription drugs, and the health care tax-advantaged reimbursement accounts), dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order (QMCSO), as long as the QMCSO does not require the Plan to provide coverage it does not otherwise provide.

A medical child support order is a judgment, decree or order (including an approval of settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law that has the force and effect of law or a judgment from a state court directing a plan administrator to cover a child by a company's group health plans.

Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received by the Plan Administrator, each affected participant and each child covered by the order will be notified of the implementation procedure to determine whether the order is valid.

If you would like to receive a copy of the UPS written procedure for determining whether an order is valid, or if you have any questions, submit your request or questions to:

Benefits Service Center  
Attention: Qualified Order Team  
PO Box 1433  
Lincolnshire, IL 60069-1433

To inquire about a medical child support order already filed with the Benefits Service Center, call the Benefits Service Center at 1-800-UPS-1508.

## When Coverage Begins

If you are newly hired, rehired in a new calendar year, or transferred into an eligible position, coverage based on the options you select under The Flexible Benefits Plan begins on the first day of the first full pay period following 30 days from the date you are:

- Hired or rehired, or
- Transferred to an eligible position.

Your tax-advantaged reimbursement account coverage (HCSA, LPSA and/or C/ECSA) is effective on the date your elected benefits begin (or would otherwise begin if you made an election). For newly hired employees in Hawaii, New York and New Jersey only, statutory short-term disability coverage begins on day one.

If you're rehired in the same calendar year in which you left UPS, the coverage (except for any reimbursement accounts) you had under The Flexible Benefits Plan prior to leaving UPS will automatically be reinstated, effective on your return date. You will also be given the opportunity to enroll in supplemental coverage.

For information about the special rules that govern the effective date of life insurance, AD&D and long-term disability coverage, see the *Life Insurance and AD&D* and the *Income Protection* sections of this booklet.

## Transition Coverage

In certain very specific conditions, The Flexible Benefits Plan may provide you and your family with transition coverage while you are making your elections for The Flexible Benefits Plan or waiting to become eligible for another UPS-sponsored plan or a plan to which UPS contributes. Details of this transition coverage are described in this section.

## Eligibility (cont.)

### Newly Hired Employees

If you're a newly hired full-time employee who previously worked as a contingent worker at UPS, your transition coverage is listed in the table below. All other coverage for newly hired employees will begin on date identified in *When Coverage Begins* in this section.

<b>Type of Coverage</b>	<b>Benefit Level</b>	<b>Coverage Category</b>
Medical, behavioral health and prescription drug*	Traditional Out-of-Area	You plus family
Vision	Exam only	You plus family
Life insurance	Basic	You plus family
AD&D	Basic	You only
Short-term disability	As described in this booklet	You only
EAP and work/life benefit	As described in this booklet	You plus family
Tobacco cessation program	As described in this booklet	You plus family

\*Non-participating pharmacy benefits apply. See Non-Participating Pharmacies in the Prescription Drugs section of this booklet.

### Current Employees Transferring to The Flexible Benefits Plan

#### From a Union-Sponsored Plan

If you're a current UPS unionized employee covered under a union-sponsored health care plan to which UPS contributes and are transferred to a union-free position eligible for The Flexible Benefits Plan, you become eligible for full coverage under The Flexible Benefits Plan on the first day of the first full pay period following 30 days from the transfer date. The Flexible Benefits Plan will provide transition coverage — as listed in the table below — for you and your family until you become eligible for full coverage under The Flexible Benefits Plan.

<b>Type of Coverage</b>	<b>Benefit Level</b>	<b>Coverage Category</b>
Medical, behavioral health and prescription drug*	Traditional Out-of-Area	You plus family
Vision	Exam only	You plus family
Life insurance	Basic	You plus family
AD&D	Basic	You only
Short-term disability	As described in this booklet	You only
EAP and work/life benefit	As described in this booklet	You plus family
Tobacco cessation program	As described in this booklet	You plus family

\*Non-participating pharmacy benefits apply. See Non-Participating Pharmacies in the Prescription Drugs section of this booklet.

### From a UPS-Administered Plan

If you are a current unionized employee covered under a UPS-administered health care plan transferring to a union-free position, you become eligible for full coverage under The Flexible Benefits Plan effective the date of your transfer.

### *Current Employees Transferring From The Flexible Benefits Plan*

#### To a Union-Sponsored Plan

If you're a current employee transferring from The Flexible Benefits Plan to a union-sponsored plan contributed to by UPS, The Flexible Benefits Plan will provide certain types of coverage (as listed in the table below) to you and your family at no cost to you, **during the waiting period, if any, before you gain eligibility under the new plan.** Your coverage ends if you terminate employment during the waiting period.

<b>Type of Coverage</b>	<b>Benefit Level</b>	<b>Coverage Category</b>
Medical, behavioral health and prescription drug	Your current election	Your current election; applicable payroll deductions are discontinued
Dental	Your current election	Your current election; applicable payroll deductions are discontinued
Vision	Your current election	Your current election; applicable payroll deductions are discontinued
Life insurance	Basic	You plus family
AD&D	Basic	You only
Short-term disability	As described in this booklet	You only
Long-term disability	As described in this booklet	Your current election, applicable payroll deductions are discontinued
EAP and work/life benefit	As described in this booklet	You plus family

#### To Another UPS-Administered Plan

If you're a current employee transferring from The Flexible Benefits Plan to another UPS-administered plan, your new plan is effective the date of your transfer. However, this effective date may be delayed if your new plan requires you to reach your seniority attainment date (SAD).

If SAD is required, your coverage in the new plan is effective on your SAD and The Flexible Benefits Plan will provide certain types of coverage (as listed in the table on the next page) to you and your family during this waiting period.

## Eligibility (cont.)

You are required to notify the Benefits Service Center as soon as possible after a dependent ceases to meet the eligibility requirements.

### To Another UPS-Administered Plan (cont.)

Your coverage ends if you terminate employment during the waiting period.

<b>Type of Coverage</b>	<b>Benefit Level</b>	<b>Coverage Category</b>
Medical, behavioral health and prescription drug	Your current election	Your current election; applicable payroll deductions are discontinued
Dental	Your current election	Your current election; applicable payroll deductions are discontinued
Vision	Your current election	Your current election; applicable payroll deductions are discontinued
Life insurance	Basic	You plus family
Life insurance	Supplemental	Your current elections, with continued applicable payroll deductions
AD&D	Basic	You only
AD&D	Supplemental	Your current elections, with continued applicable payroll deductions
Short-term disability	As described in this booklet	You only
Long-term disability	As described in this booklet	Your current election, applicable payroll deduction are discontinued
EAP and work/life benefit	As described in this booklet	You plus family
Tobacco cessation program	As described in this booklet	You plus family

## When Coverage Ends

### For All Participants

In general, coverage for you and your eligible dependents under The Flexible Benefits Plan continues as long as you meet the Plan's eligibility requirements and make any required contributions. Coverage typically ends on the date that the applicable eligibility requirements are no longer satisfied, except as otherwise noted in this booklet. Please see the *Life Events* section for additional details.

### For Your Spouse or Dependents Only

Eligibility for coverage for your children (and eligible stepchildren) ends on December 31 of the calendar year in which each

child's 19th birthday (or 25th birthday if a full-time student) occurs. If your child graduates from or leaves school before the age limit is reached, coverage continues through December 31 of the year in which he or she graduates or leaves (except as described in the *Life Events* section of this booklet), or until he or she becomes covered through another plan, if earlier.

If you lose your coverage, coverage for your dependent(s) ends on the date your coverage ends.

If your spouse or child loses eligibility for any other reason — for example, if you and your spouse divorce or your child becomes married — coverage ends on the date of the event.



## Enrollment

Eligible union-free employees have an opportunity to enroll in The Flexible Benefits Plan at initial eligibility and each year during the annual enrollment period, usually during the fall. Prior to the initial or annual enrollment period, you will receive materials describing your benefits and options available to meet the needs of you and your eligible family members. During each enrollment period, you will:

- Choose from various medical, dental, and vision coverage options, and
- Elect supplemental types of coverage offered under the Plan, at your option.

In addition, you may enroll in certain supplemental benefits, such as the personal lines of insurance, at times other than your initial or annual enrollment period. Refer to each benefit section in this booklet for more details.

In general, once you enroll, you may not change your enrollment elections until the next enrollment period. However, the Internal Revenue Code allows limited changes during the year when certain qualified events occur in your life. For more information, see the *Life Events* section of this booklet.

For more information about who is eligible for benefits under the Plan and when eligibility begins, see the *Eligibility* section of this booklet.

### Initial Eligibility Enrollment

Prior to the date you initially become eligible for the Plan, you will receive enrollment materials, including an enrollment worksheet describing your coverage options, instructions for enrolling and the deadline date for enrolling in the Plan.

If you enroll online at Your Benefits Resources, a notice confirming your successful enrollment and indicating your elections will be displayed. Print this page as a confirmation of your enrollment. You may view online at any time the enrollment elections you have made and make changes up until the enrollment deadline.

If you call the Benefits Service Center to enroll by the deadline indicated on your enrollment worksheet, you will receive by mail a Confirmation of Enrollment notice that lists the elections you made and your covered family members. Be sure to read your Confirmation of Enrollment carefully. If there are any errors on the Confirmation of Enrollment notice, you have 14 days from the date of the notice to call the Benefits Service Center at 1-800-UPS-1508 to have them corrected. If you do not contact the Benefits Service Center within 14 days, you must wait until the next annual enrollment period to change your elections or add dependents (except as the result of certain qualified life changes, as specified in the *Life Events* section of this booklet).

### If You Don't Enroll During Initial Enrollment

If you do not enroll by the deadline indicated on your enrollment worksheet, based on whether you are a full-time or part-time employee, you will receive the default coverage listed in the table below, for you only. However, if the Benefits Service Center has any of your dependents on file, your dependents will also receive coverage for the certain benefits. Once the deadline has passed, you will receive a Default Confirmation of Coverage notice, listing your assigned coverage and your covered dependents.

You have 30 days from the date of the notice to call the Benefits Service Center at 1-800-UPS-1508 to request changes to your assigned coverage. If you do not contact the Benefits Service Center within 30 days, you must wait until the next annual enrollment period to change your elections or add dependents (except as the result of certain qualified life changes, as specified in the *Life Events* section of this booklet).

In addition, you are required to notify the Benefits Service Center if any of the individuals identified on your Default Confirmation of Coverage are no longer eligible for coverage as your dependent (as defined in this booklet).

*A two-year election rule applies to your dental, vision and long-term disability option choices. See the Dental, Vision and Income Protection sections of this booklet for more information.*



## Enrollment (cont.)

Full-Time	Part-Time	Type of Coverage	Benefit Level
✓	✓	Medical, behavioral health and prescription drug*	Healthy Savings option
✓	✓	Dental	None
✓	✓	Vision*	Exam only option
✓	✓	Life insurance*	Basic
✓	✓	AD&D	Basic
✓	✓	Short-term disability	As described in this booklet
✓		Long-term disability	Option 3 — 60% of base pay, up to 5 years
✓	✓	EAP and work/life benefit*	As described in this booklet
✓	✓	Tobacco cessation program*	As described in this booklet

\*Your eligible dependents on file with the Benefits Service Center will also receive coverage for the benefits indicated.

### Annual Enrollment

During the annual enrollment period, usually in the fall, you will receive enrollment information with instructions for logging on to Your Benefits Resources through a link at [www.UPSers.com](http://www.UPSers.com) to view your enrollment options and make elections during the specified enrollment period.

If you have elected to receive paperless enrollment materials, you will be notified by email when your personalized annual enrollment information is available on Your Benefits Resources. If you have not elected paperless enrollment, your enrollment materials will be mailed to your home. Regardless of whether you are registered for paperless enrollment, you may make your elections online at Your Benefits Resources or by calling the Benefits Service Center.

If you enroll online at Your Benefits Resources, a notice confirming your successful enrollment and indicating your elections will be displayed. Print this page as a confirmation of your enrollment. You may view online at any time the enrollment elections you have made and make changes up until the enrollment deadline.

If you call the Benefits Service Center to enroll, you will receive by mail a Confirmation of Enrollment notice that lists the

elections you made and your covered family members. Be sure to read your Confirmation of Enrollment carefully. If there are any errors on the Confirmation of Enrollment notice, you have 14 days from the date of the notice to call the Benefits Service Center at 1-800-UPS-1508 to have them corrected. If you do not contact the Benefits Service Center within 14 days, you must wait until the next annual enrollment period to change your elections or add dependents (except as the result of certain qualified life changes, as specified in the *Life Events* section of this booklet).

### If You Don't Enroll During Annual Enrollment

If you do not make benefit elections during annual enrollment periods by the deadline indicated on your enrollment worksheet, you'll receive the same coverage for you and your eligible dependents that you had in the prior year, except in the following situations.

- If you wish to continue participating to a tax-advantaged reimbursement account (HCSA, LPSA and/or C/ECSA) and/or making pre-tax contributions to a health savings account (HSA), you must elect a contribution amount each year.

- If your dependent child is a full-time student aged 19 or older, you must certify your student's full-time status for the coming year (except as noted in *What If...Your Child Takes a Medically Necessary Leave From School* in the *What If...* section of this booklet) in order to maintain his or her coverage. If you do not certify student status, your child's coverage will end on December 31 of the current Plan year.

### ***Your Student Loses Coverage***

If your child's coverage ended because you didn't certify student status, coverage can be reinstated effective the date your child returns to school full time (not retroactive to January 1). You must call the Benefits Service Center at 1-800-UPS-1508 within 60 days of the return-to-school date in order to add your dependent to your coverage.

If coverage ended because your child didn't return to school as a full-time student, your child's coverage can be reinstated if he or she returns to school at a later date. You must call the Benefits Service Center at 1-800-UPS-1508 within 60 days of the return-to-school date in order to add your dependent to your coverage. Your child will be added back to coverage effective the date he or she returned to full-time student status, as long as your child is under age 25 and otherwise meets all eligibility requirements.

If your child didn't return to school because he or she took a medically necessary "school leave," you must call the Benefits Service Center at 1-800-UPS-1508 as soon as possible after the event occurs but **prior** to the date that either:

- Your child's coverage ends or
- Your student certification documents are due.

For more information, see *What If...Your Child Takes a Medically Necessary School Leave* in the *What If...* section.

### ***Opting In to the Network***

The Flexible Benefits Plan offers a choice of medical options, as described in the *Medical Benefits* section of this booklet. If your home address is within the medical Preferred Provider Organization (PPO) network service area designated for your state as indicated on your enrollment information, you may enroll in either the Traditional PPO or the Healthy Savings PPO. Employees who live within a Kaiser Health Maintenance Organization (HMO) network area in either California or Hawaii have an additional network coverage option.

If your home address is outside the PPO network service area designated for your home state, you may choose between the Traditional Out-of-Area or Healthy Savings Out-of-Area option. You may also choose to "opt in" to either the Traditional PPO or Healthy Savings PPO — if you find the providers in the PPO network designated for your home state are convenient to you — to receive in-network benefits. You may elect to opt in to the medical network by calling the Benefits Service Center.

Once you opt in to a medical network, you are required to remain in the network for the rest of that Plan year. You will automatically remain in the network from year to year unless you elect during annual enrollment to return to out-of-area coverage.

Medical network service areas are subject to change from time to time. You should refer to your annual enrollment materials to learn whether any network changes will apply to your home address.

### If a Dependent Becomes No Longer Eligible for Coverage

*You must notify the Benefits Service Center immediately if a family member ceases to be eligible for coverage as your dependent under the Plan, even if you can't or don't want to make any changes to your coverage.*

*Otherwise, you may be required to repay the Plan for any benefits paid by the Plan for that dependent between the date he or she is no longer eligible and the date you notified the Benefits Service Center (even if you called within 60 days of the event). See Right of Recovery in the Filing a Claim section for more information on the Plan's right to reimbursement.*

## Life Events

The Flexible Benefits Plan is regulated by the Internal Revenue Code, and changes during the year are restricted. However, the IRS realizes that certain life events do occur that create the need for you to change your benefit choices in the middle of a Plan year.

As a general rule, you will be allowed to make coverage changes only if the life event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. Your change in coverage must be consistent with the life event. For example; if you have a baby, you can change your level of medical coverage from employee only to employee plus family, but you may not decrease your life insurance.

If you are making pre-tax payroll contributions to your health savings account (HSA), you may change your election up to once a month, for any reason. You can expect the change to be effective as soon as administratively possible, depending on the date the change was requested. See the *Medical Benefits* section of this booklet for more information on Health Savings Accounts.

### 60-Day Time Limit

You must call the Benefits Service Center at 1-800-UPS-1508 within 60 days of the date of the event to request a change in coverage. If you don't call to change coverage within the 60-day period, you must wait until the next annual enrollment period.

## When Changes to Coverage Become Effective

<b><i>Benefit</i></b>	<b><i>Effective Date of Revised Coverage</i></b>
All benefits not listed below	The change is retroactive to the date of the event.
Life insurance	For life insurance requiring evidence of insurability (EOI), the requested level of coverage is effective when approved by Prudential. Until then, the highest level of coverage (up to the level requested) not requiring evidence of insurability is effective.  In certain circumstances, coverage for you or your dependents could be delayed. See the <i>Life Insurance and AD&amp;D</i> section of this booklet for further details.
Tax-advantaged reimbursement accounts (HCSA, LPSA or C/ECSA)	If you change your contribution to the tax-advantaged reimbursement accounts, the effective date of an approved change of coverage is the date you notify the Benefits Service Center.

## Tax-Advantaged Reimbursement Account Changes

The following rules apply to any mid-year changes you want to make to the amount you elect to contribute through payroll deductions to a tax-advantaged reimbursement account (HCSA, LPSA or C/ECSA) as a result of a qualified life event; for example, due to marriage or birth of a child.

Some life events, however, make you eligible to stop your account contributions altogether — see the *Allowable Mid-Year Coverage Changes* table in this section. For more information about reimbursement accounts and contribution elections, see the *Tax-Advantaged Reimbursement Accounts* section of this booklet.

### *Increasing Your Annual Contribution*

Your new contribution per pay period is calculated by dividing the amount of the increase by the number of pay periods remaining in that calendar year. The result is then added to your current contribution per pay period. The amount of the increase is available to be reimbursed to you for expenses incurred after the effective date of the change.

For example, if you are paid monthly and increase your annual contribution from \$1,200 to \$1,500 in mid-September, the additional \$300 is prorated over the three remaining monthly pay periods, so that \$100 is added to your current contribution per paycheck.

### *Decreasing Your Annual Contribution*

Your new contribution per pay period is calculated by subtracting the total amount you have contributed thus far during the year from your revised annual contribution amount. The difference is then divided by the number of pay periods remaining in that calendar year, and the result is subtracted from your current per-pay-period contribution.

For example, suppose you are paid monthly and decrease your annual contribution from \$1,200 to \$600 at the end of February. At that time you would have contributed \$100 per month for two months, for a total of \$200. The \$200 you've already contributed is subtracted from your revised annual contribution of \$600. The difference of \$400 is divided by the 10 months remaining in the year. So your new contribution becomes \$40 per monthly paycheck.

You may not decrease your account to an amount that is less than what you have already contributed, or for which you have already been reimbursed. In the example above, you could not decrease your account to less than \$200, because you have already contributed \$200.

## Life Events (cont.)

### Allowable Mid-Year Coverage Changes

Only the changes listed are allowed.

Event	Medical or Cancer Insurance	Dental	Vision	AD&D	Employee Life*	Spouse's Life*	Children's Life*	Legal	LTD	HCSA or LPSA	C/ECSA
Marriage	If covered, change family status and coverage option. If opted out, start coverage. If now have outside coverage, can opt out	If covered, change family status and coverage option. If opted out, start coverage. If now have outside coverage, can opt out	If covered, change family status. If opted out, start coverage. If now have outside coverage, can opt out	Change family status	Increase coverage	Add coverage	Add coverage	Start coverage; change family status	No changes	Start or increase contributions	Start, stop or change contributions
Divorce; legal separation; annulment	If covered, change family status and coverage option. If opted out, start coverage if lost under spouse's plan	If covered, change family status. If opted out, start coverage if lost under spouse's plan	Change family status. Increase coverage if lost under spouse's plan	Change family status	Increase or decrease coverage	Drop coverage	No changes	Start or drop coverage; change family status	No changes	Stop or decrease contributions	Start, stop or change contributions
Birth; adoption or placement for adoption; child gains eligibility	If covered, increase family status and coverage option. If opted out, start coverage	If covered, increase family status and change coverage option. If opted out, start coverage	If covered, increase family status. If opted out, start coverage	Increase family status	Increase coverage	Add coverage	Add or increase coverage	Start coverage; change family status	No changes	Start or increase contributions	Start or increase contributions
Death of spouse	If covered, change family status and coverage option. If opted out, start coverage if lost under spouse's plan	If covered, change family status. If opted out, start coverage if lost under spouse's plan	Change family status. Increase coverage if lost under spouse's plan	Change family status	Increase or decrease coverage	Drop coverage	No changes	Start or drop coverage; change family status	No changes	Stop or decrease contributions	Start, stop or change contributions
Death of child; loss of child's eligibility; termination of Adoption Proceedings	Decrease family status	Decrease family status	Decrease family status	Decrease family status	No changes	No changes	Drop coverage	No changes	No changes	Stop or decrease contributions	Stop or decrease contributions
Dependent loses eligibility for reimbursement accounts	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	Stop or decrease contributions	Stop or decrease contributions
Gain or loss of eligibility for Medicare or Medicaid	If covered, change family status and coverage option. If opted out, start coverage. If now have outside coverage, can opt out	If covered, change family status and coverage option. If opted out, start coverage	Change family status	Change family status	No changes	No changes	No changes	Start, stop or change coverage	No changes	No changes	No changes
Loss of coverage under state children's health insurance program	If covered, change family status and coverage option. If opted out, start coverage	If covered, change family status and coverage option. If opted out, start coverage	If covered, change family status and coverage option. If opted out, start coverage	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes

## Allowable Mid-Year Coverage Changes (cont.)

Only the changes listed are allowed.

Event	Medical or Cancer Insurance	Dental	Vision	AD&D	Employee Life*	Spouse's Life*	Children's Life*	Legal	LTD	HCSA or LPSA	C/ECSA
Become eligible for qualifying health coverage premium assistance under Medicaid or state children's health insurance plan	If covered, increase family status and change coverage option. If opted out, start coverage	If covered, increase family status and change coverage option. If opted out, start coverage	If covered, increase family status and change coverage option. If opted out, start coverage	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes
Loss of outside medical coverage eligibility with other employment	If opted out, start coverage. Increase family status if dependent lost coverage elsewhere and change option	If opted out, start coverage if lost elsewhere. Increase family status if dependent lost coverage elsewhere and change option	No changes	No changes	No changes	No changes	No changes	No changes	No changes	Start or increase contributions if health coverage is lost due to employment change	No changes
Gain in spouse's employment or coverage; open enrollment period differs from employee's	If covered, change family status. If now have outside coverage, can opt out	If covered, change family status	Change family status	Change family status	No changes	Add or increase coverage	No changes	Start, stop or change coverage	No changes	Start or increase contributions (Spouse gains employment); No changes (Open Enrollment, Coverage)	Start, stop or change contributions
Loss of DMO access	No changes	Change to Option 1 or 2	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes
Reduction in earnings due to leave of absence**	No changes	No changes	No changes	No changes	Decrease coverage	Stop or decrease coverage	Stop or decrease coverage	Start or drop coverage; change family status	No changes	No changes	Stop or decrease coverage
Change from full-time to part-time	No changes	No changes	No changes	No changes	Decrease coverage	Stop or decrease coverage	Stop or decrease coverage	Start or drop coverage; change family status	Drop coverage	No changes	Stop or decrease coverage
Change in child or elder care provider or cost	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	No changes	Start, stop, or change contributions (limited to four changes per year)
Court-ordered coverage for child***	As dictated by court order	As dictated by court order	As dictated by court order	No changes	No changes	No changes	No changes	No changes	No changes	As dictated by court order	No changes

\*See the Life Insurance and AD&D section of this booklet for details about coverage maximums and evidence of insurability requirements.

\*\*Except military leave. Personal leaves are administered according to COBRA provisions.

\*\*\*Must comply with QMCSO. See the Eligibility section for more information.

## What If...

### ...Your Child Takes a Medically Necessary Leave from School?

As explained in the *Eligibility* section of this booklet, eligibility for coverage for your children (and eligible stepchildren) ends on December 31 of the calendar year in which your child reaches the dependent eligibility age limit, graduates, leaves school, or becomes covered through another plan (whichever is earliest).

However, if it is medically necessary for your covered child to take a “school leave,” meaning the child stops being a full-time student solely as a result of a serious illness or injury (as determined by the Plan Administrator), your child may continue to be covered under the Plan on the same terms and conditions as before the school leave. This coverage continues until the earlier of either:

- 12 months following the year in which the school leave began; or
- The date coverage would otherwise end under the Plan (for example, the child reaches the dependent eligibility age limit or you terminate your employment).

In order for coverage to continue, you must provide the Benefits Service Center a written certification from the child’s physician that the child suffers from a serious illness or injury and that the school leave is medically necessary. Unless prohibited by Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) rules, the school leave is considered a “qualifying event” for purposes of COBRA, and this continuation of coverage will be applied toward the COBRA continuation coverage period. See the *Continuation of Coverage Under COBRA* section of this booklet for more information about COBRA continuation coverage.

### ...You Leave UPS?

If you leave UPS before taking early or normal retirement, your short-term disability and long-term disability coverage ends on the date you leave.

For other Plan benefits, coverage for you and your eligible dependents ends on the date shown in the table below.

<i><b>For an employee paid...</b></i>	<i><b>Coverage ends on the last day of...</b></i>
Weekly	The pay period following the pay period during which you became ineligible
Monthly or semi-monthly	The pay period during which you became ineligible

You and your covered dependents can continue health coverage from The Flexible Benefits Plan under COBRA for a period of time after your termination date. See the *Continuation of Coverage Under COBRA* section of this booklet for more information.

You may convert life insurance for yourself and your dependents to individual policies. You cannot convert AD&D coverage to an individual policy. See *If You Leave UPS or Retire* in the *Life Insurance and AD&D* section for more details about continuing life insurance coverage.

### ...You Retire?

If you retire from UPS and are eligible for retiree health coverage, your active coverage ends on the last day of the month following 30 days from your retirement date.

If you take early or normal retirement based on the provisions of the UPS Retirement Plan, you and your eligible dependents may be eligible for retired



employee medical, dental and vision coverage from the UPS Retired Employees' Health Care Plan (REHCP) if you meet the eligibility rules of that Plan. You'll receive a separate Summary Plan Description of your retiree health coverage when you retire.

You and your eligible dependents can continue health coverage from The Flexible Benefits Plan under COBRA for a period of time after your termination or retirement date. (See the *Continuation of Coverage Under COBRA* section of this booklet for more information.) Also, you may convert the life insurance policies for you, your spouse and your children to individual policies. (See *If You Leave UPS or Retire* in the *Life Insurance and AD&D* section for more details about continuing life insurance coverage). You cannot convert AD&D coverage to an individual policy.

You choose whether to elect COBRA coverage from The Flexible Benefits Plan or participate in the REHCP (assuming you meet that plan's eligibility requirements). You can elect COBRA coverage under The Flexible Benefits Plan and then participate in the REHCP when COBRA coverage ends. After the end of your 60-day election period under COBRA, you cannot elect coverage from the REHCP and then switch to COBRA coverage under The Flexible Benefits Plan.

### ***Life Insurance During Retirement***

Your life insurance can be continued through an individual policy with Prudential at the current level of coverage at the time you retire, without evidence of insurability (EOI). You are not allowed to increase your life insurance coverage at that time.

It's a good idea to review the *Life Insurance and AD&D* section of this

booklet in detail, paying particular attention to the information about conversion and portability. You should also review the Prudential Enrollment Kit for detailed information about supplemental life insurance portability.

### **...You Die?**

If you die while you're covered by The Flexible Benefits Plan as an active employee, UPS will continue coverage under COBRA for your eligible dependents — at no cost to your dependents — through the last day of the 13th calendar month following the date of your death. For example, if your death occurs on February 2, dependent coverage continues through March 31 of the following year. Your covered dependents are automatically enrolled for this 13-month coverage period.

When this UPS-paid coverage ends, your dependents may extend health care coverage in keeping with COBRA provisions for up to an additional 23 months, for a total of 36 months of coverage from the date of your death. The full cost of extended coverage beyond the initial 13-month period will be billed to your dependents according to the COBRA provisions of this Plan. See the *Continuation of Coverage Under COBRA* section of this booklet for more information. Life insurance for your spouse and children may be converted to individual policies.

Your dependents are eligible for this 13-month extension of coverage only if you and your dependents were covered by The Flexible Benefits Plan at the time of your death. For example, if you are on military leave, or if you opted out of medical coverage for yourself or your dependents, your dependents would not be eligible.



## What If... (cont.)

### ...You're Laid Off?

If you're laid off from your UPS position (and are recorded as such in the UPS eligibility system), your Flexible Benefits Plan coverage is continued until the last day of the month following the month in which your layoff begins. You continue to pay your share, if any, of the cost of your coverage. You can elect to continue your medical, dental, vision, HCSA and LPSA coverage through COBRA. See the *Continuation of Coverage Under COBRA* section for more information. You may also choose to convert life insurance for yourself, your spouse and your children to individual policies.

### ...You Have Jury Duty?

If you have jury duty, your Flexible Benefits Plan participation continues. You make contributions as if you were at work.

### ...You Become Disabled?

You and your dependents continue to have medical protection if you are on an approved disability leave. See the *Income Protection* section of this booklet for a full description of your short-term and long-term disability benefits, including health care coverage.

See *Payroll Deductions and Opt-Out Credits* and *Reimbursement Accounts* under *Other Types of Leave* in this section. Both topics apply to an approved disability leave.

### ...You Take an Approved Leave of Absence?

#### **FMLA Leave**

If you're on an approved leave of absence as provided by the Family and Medical Leave Act of 1993 (FMLA) or UPS policy, full medical, dental, vision, life insurance, AD&D and employee long-term disability coverage for you and your dependents can

be continued during your leave for up to the approved FMLA time period. You'll need to continue to pay your share, if any, of the costs of the coverage.

If your leave extends beyond 20 days, you may be billed and must make full and timely payments or your coverage will be terminated. If you are billed, you must pay the billed amount; it will not be deducted from your paycheck when you return to work. If you elected not to continue coverage during your FMLA time period, your coverage will be reinstated when you return to work, and you will experience a gap in your coverage.

If your leave does not extend beyond 20 days, deductions and credits will be applied to your first paycheck upon returning to work.

If you notify UPS in writing that you want to extend your leave beyond the applicable approved FMLA time period, your approved extension of leave is considered a personal leave. Your coverage from the Plan can continue under COBRA, provided you make an election and you pay the full cost of coverage. See *Personal Leave* in this section for more information.

Special rules apply to HCSA and LPSA contributions during your FMLA leave. See *Special HCSA/LPSA Rules for FMLA Leaves Only* in this section.

#### **Military Leave**

Except for military leaves of less than 31 days (or as otherwise required by federal law), your health care benefits cease and therefore deductions and/or credits also cease. However, you may be eligible to continue health coverage for you and your covered dependents up to 24 months from either the date the leave began or the date that you fail to return to work — whichever is earlier — as required under USERRA. The USERRA

continuation period will run concurrently with the COBRA period described in the *Continuation of Coverage Under COBRA* section of this booklet.

Although supplemental coverage (such as long-term disability, legal plan, and supplemental life and AD&D insurance) is not subject to COBRA, you may also elect to continue any or all of your supplemental coverage during your leave. If you choose not to continue your supplemental life insurance, you must provide evidence of insurability (EOI) in order to begin coverage again when you return to work.

Regardless of whether you elect to continue your coverage, UPS-provided basic life and AD&D insurance and short-term disability are continued up to 12 months, or until the date you terminate employment; whichever is earlier.

### ***Personal Leave***

You may continue coverage for you and your covered dependents if you are on a personal leave of absence. You are responsible for paying the full cost of coverage — not just your cost share — during a personal leave. Medical (including behavioral health, prescription drug, the HCSA and LPSA), dental and vision coverage are continued through COBRA, according to the COBRA provisions described in the *Continuation of Coverage Under COBRA* section of this booklet.

Although supplemental coverage (such as long-term disability, legal and supplemental life and AD&D insurance) is not subject to COBRA, you may also elect to continue any or all of your supplemental coverage during your leave. If you choose not to continue your supplemental life insurance, you must provide evidence of insurability (EOI) in order to begin coverage again when you return to work.

Regardless of whether you elect to continue your coverage, UPS-provided basic life and AD&D insurance and short-term disability are continued up to 12 months or until the date you terminate employment, whichever is earlier.

### **If You Don't Make Timely Payments While on a Personal Leave**

If you are responsible for some or all of the cost of your health plan coverage while on leave and elect to continue coverage, you must make full and timely payments. If you fail to do so, your coverage will be terminated according to the following guidelines.

- Any amounts received by the COBRA administrator will be applied first to your COBRA coverage.
- If the amount is insufficient to pay for your COBRA coverage, all COBRA and supplemental coverage will be terminated.
- If the amount is sufficient to pay for your COBRA coverage, but insufficient to pay for your supplemental coverage, your supplemental coverage will be terminated.

If your supplemental life insurance coverage is dropped due to non-payment, you must provide evidence of insurability (EOI) to begin coverage again upon return to work.

Upon return from your leave, your coverage other than reimbursements accounts will be reinstated.

### ***Payroll Deductions and Opt-Out Credits***

As long as you are receiving a paycheck from UPS, deductions or credits will continue to be applied to your paycheck while you are on leave. However, if you are not receiving a paycheck and your leave is 20 days or less, deductions or credits will be applied to your first paycheck when you return to work.

## Special HCSA/LPSA Rules for FMLA Leaves Only

**To reinstate your full annual HCSA or LPSA contribution upon return from your FMLA leave:** You may also choose, upon return from your FMLA leave, to reinstate your full annual HCSA or LPSA contribution amount and “catch up” on contributions you missed while on leave. You must call the Benefits Service Center within 30 days of your return to work to activate this option. The total amount of contributions that you do not make while on a FMLA leave will be divided by the number of remaining pay periods during the Plan year and added to your regular contribution amount per pay period. Expenses incurred during your FMLA leave are not eligible for reimbursement from your HCSA or LPSA.

**To maintain your full annual HCSA or LPSA contribution and to be eligible for reimbursement for expenses incurred during your leave:** You may elect at the time you begin your FMLA leave to catch up on pre-tax HCSA or LPSA payroll contributions when you return. The total amount of contributions that you do not make while on a FMLA leave will be divided by the number of remaining pay periods during the Plan year and added to your regular contribution amount per pay period. Eligible expenses incurred during your FMLA may be reimbursed through your HCSA or LPSA, if funds are available.

## What If... (cont.)

If your leave extends beyond 20 days (or 31 days for a military leave), you may be billed. If you fail to make timely payment of this bill, your coverage will be terminated.

If your supplemental life insurance is terminated for non-payment, you must provide evidence of insurability (EOI) to begin coverage again upon return to work (except in the case of a military leave).

### When You Return to Work

Upon your return to work, your full medical, dental, vision and LTD coverage is reinstated if your coverage was terminated during your leave. If your supplemental life insurance coverage was dropped due to non-payment, you must provide evidence of insurability (EOI) to begin coverage again upon return to work.

### Reimbursement Accounts

#### Child/Elder Care Spending Account (C/ECSA)

Your C/ECSA contributions will stop during your leave. Upon return to work, your contribution amount per pay period will be reinstated automatically, unless you notify the Benefits Service Center, within 60 days upon your return to work, to revoke your election. If you experienced a qualified life event, you may change certain elections (see the *Life Events* section of this booklet.) Only eligible expenses incurred prior to your date of leave and after your return to work (unless you revoke your election) will be eligible for reimbursement.

#### Health Care Spending Account (HCSA) or Limited Purpose Spending Account (LPSA)

If you are an Administrative or Technical employee, during a leave your contributions

to your HCSA or LPSA stop. You can choose to continue contributions on an after-tax basis; if you do, any eligible expenses incurred during your leave will be eligible for reimbursement. To continue your contributions during your leave, you must call the Benefits Service Center within 60 days of the start of your leave.

If you do not call the Benefits Service Center to continue your contributions during your leave, your HCSA or LPSA contributions will stop during your leave. Only expenses incurred prior to your leave and after your return to work will be eligible. Upon your return to work, your contribution amount per pay period will be reinstated automatically, and your annual contribution amount will be reduced by the amount not contributed during your leave. For example, suppose you are paid monthly and your annual contribution amount is \$1,200. If you are on leave for three months and miss three payroll contributions of \$100 each, your revised annual contribution amount will be reduced by \$300, to \$900.

If you are a Management or Specialist employee on an approved medical leave or Workers’ Compensation leave, your contributions continue to be deducted from your paychecks; and any eligible expenses incurred during your leave will be eligible for reimbursement.

Special rules apply to HCSA or LPSA contributions if you are on a FMLA leave. See *Special HCSA/LPSA Rules for FMLA Leaves* in this section.

#### Health Savings Account (HSA)

Your HSA contributions will stop during your leave. Your per-pay-period HSA contributions will resume upon your return.

## ...You Change Your Home Address?

It's important to keep your personal information current in the UPS eligibility system. This includes your home address, phone number and contact information. Moving to your new address may have an impact on your medical and/or dental coverage, as shown in the table below. See the *Medical* and *Dental* sections of this booklet for more information about networks, including health maintenance organizations (HMOs) and dental maintenance organizations (DMOs).

If you move during the Plan year, you are not allowed to change your coverage category (whom you choose to cover) until the next annual enrollment.

*It's easy to update your personal information by clicking the Edit Your Profile link on any page at [www.UPSers.com](http://www.UPSers.com). Or, contact your local Human Resources representative to update your information.*

<b><i>If you previously lived...</i></b>	<b><i>And you move...</i></b>	<b><i>Then...</i></b>
Within a medical or dental network	Within the same network	There will be no changes to your coverage.
Within a medical or dental network	Into a different network	You'll receive a notification from the Benefits Service Center indicating your new coverage as of the date your address was changed.
Outside any medical or dental network area	Into a medical or dental network area	You'll receive a notification from the Benefits Service Center indicating your coverage in your new network as of the date your address was changed.
Within a medical or dental network	Outside any medical or dental network area	You'll receive a notification from the Benefits Service Center indicating your new coverage as of the date your address was changed. You may call the Benefit Service Center to "opt in" to a nearby network if you find it convenient.
Within a Kaiser HMO network in California or Hawaii	Outside a Kaiser HMO network area	You'll receive a notification from the Benefits Service Center indicating your new coverage as of the date your address was changed.
Outside of a Kaiser HMO network	Into a Kaiser HMO network in California or Hawaii	You will receive a notification from the Benefits Service Center, offering you the opportunity to select the Kaiser HMO option. If you do not select the Kaiser HMO option, you must keep your current medical option.
Outside a DMO network	Into a DMO network	You will receive a notification from the Benefits Service Center, offering you the opportunity to select the DMO option. If you do not select the DMO, you must keep your current dental option.
Inside a DMO network	Outside a DMO network	You will receive a notification from the Benefits Service Center, asking you to select a new dental option.

## Summary of Benefits

The tables on these pages represent a summary of the actual benefits described in this booklet. All benefits are subject to additional Plan limits, as described in the specific benefit plan sections of this booklet. If this summary conflicts with the specific benefit plan sections of this booklet, the specific benefit plan sections control.

### Medical Benefits

Your medical benefits are administered by either Aetna or UnitedHealthcare, depending on the state where you live. Refer to your enrollment worksheet for the name of your medical claims administrator, or call the Benefits Service Center at 1-800-UPS-1508. To contact your medical claims administrator, see *Member Services* on the back cover of this booklet.

**The annual deductibles and annual out-of-pocket maximums work very differently for participants in the Traditional medical option and the Healthy Savings medical option.** Please see pages 34 to 35 in the *Medical Benefits* section of this booklet for complete information.

	Traditional Medical Option			Healthy Savings Medical Option		
	In-Network	Out-of-Network*	Out-of-Area*	In-Network	Out-of-Network*	Out-of-Area*
Medical Basic Provisions						
Annual deductible	\$250 individual \$500 family	\$500 individual \$1,000 family	\$250 individual \$500 family	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family	\$1,500 individual \$3,000 family
Annual out-of-pocket maximum	\$2,000 individual \$4,000 family	\$4,000 individual \$8,000 family	\$2,000 individual \$4,000 family	\$3,000 individual \$6,000 family	\$6,000 individual \$12,000 family	\$3,000 individual \$6,000 family
Lifetime maximum	\$2,000,000					
Preventive Medical Care — See the <i>Medical</i> Section for Important Information						
Routine physical exams — begin at birth	100%	Not covered	100%	100%	Not covered	100%
Routine OB/GYN exam	100%	Not covered	100%	100%	Not covered	100%
Routine mammogram	100%	Not covered	100%	100%	Not covered	100%
Routine immunizations	100%	Not covered	100%	100%	Not covered	100%
Preventive tests	100%	Not covered	100%	100%	Not covered	100%
Physician Charges — Non-Preventive Care						
Office visit	85%	65%	85%	80%	60%	80%
Allergy testing and treatment	85%	65%	85%	80%	60%	80%
Inpatient surgery	85%	65%	85%	80%	60%	80%
Outpatient surgery	85%	65%	85%	80%	60%	80%
Hospital Facility Charges						
Inpatient services	85%	65%	85%	80%	60%	80%
Outpatient services	85%	65%	85%	80%	60%	80%
Emergency room, emergency	85%	85%	85%	80%	80%	80%
Emergency room, non-emergency	85%	65%	85%	80%	60%	80%
Maternity						
Physician charges	85%	65%	85%	80%	60%	80%

\*All out-of-network and out-of-area medically necessary services are subject to reasonable and customary (R&C) limits.

## Medical Benefits (cont.)

	Traditional Medical Option			Healthy Savings Medical Option		
	In-Network	Out-of-Network*	Out-of-Area*	In-Network	Out-of-Network*	Out-of-Area*
<b>Other Covered Charges</b>						
Diagnostic x-ray and lab (includes preadmission testing)	85%	65%	85%	80%	60%	80%
Hospice care — inpatient	85%	65%; limit 30 days	85%; limit 30 days	80%	60%; limit 30 days	80%; limit 30 days
Hospice care — outpatient	85%	65%; limit \$5,000	85%; limit \$5,000	80%	60%; limit \$5,000	80%; limit \$5,000
Skilled nursing facility	85%	65%; limit 60 days/year	85%; limit 60 days/year	80%	60%; limit 60 days/year	80%; limit 60 days/year
Outpatient private duty nursing	85%; limit 560 hours/year	65%; limit 560 hours/year	85%; limit 560 hours/year	80%; limit 560 hours/year	60%; limit 560 hours/year	80%; limit 560 hours/year
Home health care — limit 4 hrs./visit	85%	65%; limit 120 visits/year	85%; limit 120 visits/year	80%	60%; limit 120 visits/year	80%; limit 120 visits/year
Ambulance, emergency	85%	85%	85%	80%	80%	80%
Ambulance, non-emergency — if medically necessary	85%	65%	85%	80%	60%	80%
Durable medical equipment	85%	65%	85%	80%	60%	80%
Chiropractor — limit 60 visits/year	85%	65%	85%	80%	60%	80%
Podiatrist — limit 60 visits/year	85%	65%	85%	80%	60%	80%
Rehabilitation	85%	65%; limit 60 visits/year combined in- and outpatient, combined physical, occupational and speech	85%; limit 90 visits/year combined in- and outpatient, combined physical, occupational and speech	80%	60%; limit 60 visits/year combined in- and outpatient, combined physical, occupational and speech	80%; limit 90 visits/year combined in- and outpatient, combined physical, occupational and speech

\*All out-of-network and out-of-area medically necessary services are subject to reasonable and customary (R&C) limits.



## Summary of Benefits (cont.)

### Behavioral Health Benefits

Your behavioral health benefits are administered by ValueOptions. All treatment must be determined by ValueOptions to be medically necessary. For contact information, see *Member Services* on the back cover of this booklet.

	Traditional Medical Option			Healthy Savings Medical Option		
	In-Network	Out-of-Network	Out-of-Area*	In-Network	Out-of-Network	Out-of-Area*
Mental health – inpatient	85%	65%	N/A	80%	60%	N/A
Mental health – outpatient	85%	65%	N/A	80%	60%	N/A
Substance abuse treatment	85%	65%	N/A	80%	60%	N/A

\*ValueOptions network providers are available in all areas.

### Prescription Drug Benefits

Your prescription drug benefits are administered by Medco. For contact information, see *Member Services* on the back cover of this booklet.

	Traditional Option	Healthy Savings Option	Retail Pharmacy Per-Script Min/Max*	Medco By Mail Per-Script Min/Max*
Generics	80%	80% after deductible; deductible waived if preventive care med.	\$5/\$100	\$10/\$200
Preferred brands**	80%	80% after deductible; deductible waived if preventive care med.	\$25/\$150	\$50/\$300
Non-preferred brands** and non-sedating antihistamines	50%	50% after deductible; deductible waived if preventive care med.	\$50/\$300	\$100/\$600

\*The per-script minimum/maximum applies to both the Traditional and Healthy Savings medical options. In the Healthy Savings option, the per-script minimum and maximum applies only after the annual deductible has been met or if the drug is considered a preventive care medication. Until the annual deductible for this medical option has been met, you are responsible for the entire cost of the prescription.

\*\*If you purchase a brand-name drug when a generic is available, you must also pay the difference between the brand and generic drug costs. This difference is not included in the per-script or annual out-of-pocket maximum.

## Dental Benefits

Your dental benefits are administered by Aetna. For contact information, see *Member Services* on the back cover of this booklet.

	Dental Option 1 Dental PPO		Dental Option 2 Dental PPO		Dental Option 3 DMO
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network***
Annual Deductible*	\$50/\$100	\$50/\$100	\$50/\$100	\$50/\$100	None
<b>The option will pay</b>					
Preventive	100%	100%	100%	100%	100%
Basic	80%	60%	50%	50%	100%
Major	80%	60%	50%	50%	80%
Orthodontia	50%	50%	50%	50%	50%
<b>Maximum benefits</b>					
Annual maximum per individual (excluding orthodontia)	\$2,500	\$1,500	\$1,000	\$1,000	No limit
Combined lifetime maximum for orthodontia and TMJ treatment for each dependent child under age 19	\$2,000	\$2,000	\$2,000	\$2,000	Orthodontia — no limit, TMJ — \$2,000
Lifetime maximum for TMJ treatment for adults (age 19 and over)	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000

\* Preventive and orthodontic services are not subject to the Option 1 and 2 deductibles. If you receive dental services from both in- and out-of-network dental providers, the annual maximum benefits cross-apply. This means you are not eligible to receive both in-network and out-of-network annual maximum benefits.

\*\* Out-of-network services are subject to reasonable and customary (R&C) limits.

\*\*\* If you enroll in Dental Option 3, you must choose a personal dentist from the DMO network. Very limited benefits are available for services provided by a dental provider who is not your DMO personal dentist.



## Summary of Benefits (cont.)

### Vision Benefits

Your vision benefits are administered by Vision Service Plan (VSP). For contact information, see *Member Services* on the back cover of this booklet.

	Vision Exam Only		Vision Frames and Lenses	
	VSP Provider	Non-VSP Provider**	VSP Provider	Non-VSP Provider**
Eye exam	100%*	Up to \$70	100%*	Up to \$70
Single-vision lenses	N/A	N/A	100%*	Up to \$30
Bifocal lenses	N/A	N/A	100%*	Up to \$40
Trifocal lenses	N/A	N/A	100%*	Up to \$50
Frames	N/A	N/A	100%*	Up to \$45
Standard daily-wear contact lenses in lieu of glasses	N/A	N/A	Up to \$100	Up to \$60

\* Up to VSP plan limits.

\*\* Services provided by a non-VSP vision provider are subject to reasonable and customary (R&C) limits.

### Additional Basic Benefits

UPS provides these types of coverage to employees eligible for The Flexible Benefits Plan. See the related section in this booklet for more information about each of these benefits. For contact information, see *Member Services* on the back cover of this booklet.

Your Security	
Income protection — Short-term disability (STD)	The Plan pays a portion of your base pay, to a maximum number of weeks. Refer to your SPD insert for details
Income protection — Long-term disability (LTD)	<p>The Plan benefit pays a percentage of your monthly salary, for a period of time you elect:</p> <ul style="list-style-type: none"> <li>• Option 1 — 50% of monthly base pay</li> <li>• Option 2 — 60% of monthly base pay</li> <li>• Option 3 — 60% of monthly base pay to a maximum of 5 years</li> </ul> <p>UPS makes a contribution toward the cost of your LTD coverage. You are responsible for the cost of coverage that exceeds UPS's contribution.</p>
Basic employee life insurance	The Plan provides 12 times your monthly salary*. You can purchase additional coverage at a discounted group rate
Basic spouse's life insurance	The Plan provides \$2,000 of coverage for your spouse. You can purchase additional coverage at a discounted rate
Basic children's life insurance	The Plan provides \$2,000 of coverage for your children. You can purchase additional coverage at a discounted rate
Basic employee AD&D insurance	The Plan provides 12 times your monthly salary* for basic accidental death and dismemberment coverage for employees. You can purchase additional coverage at a discounted group rate
Valuable Extras	
Solutions — Your EAP and Work/Life Benefit	Provides practical solutions, information, advice and support for a wide range of work/life issues
Quit For Life® tobacco cessation program	Provides assistance to help you stop using tobacco products (requires enrollment)
Adoption assistance	UPS pays \$3,500 (or \$5,000 for special needs children) for qualified adoption expenses

\*Monthly salary for purposes of this benefit refers to your base pay, excluding bonuses or other incentive compensation.

## Supplemental Benefits

These types of optional coverage are available to employees eligible for The Flexible Benefits Plan. See the related section in this booklet for more information about each of these benefits. For contact information, see *Member Services* on the back cover of this booklet.

Your Security	
Employee supplemental life coverage	Up to a maximum of \$1 million of coverage, in \$1,000 increments
Employee supplemental AD&D coverage	Up to a maximum of \$1 million of coverage, in \$1,000 increments
Family supplemental AD&D coverage	The benefit amount is determined by your covered dependents on file with the Benefits Service Center. See the <i>Life Insurance and AD&amp;D</i> section for details
Spouse's life insurance	Up to a maximum of \$500,000, in \$1,000 increments
Children's life insurance	Up to a maximum of \$30,000, in \$1,000 increments
Personal lines of insurance	Low group rates for auto and home insurance, and a choice of vendors
Critical illness insurance	Pays a lump-sum benefit payment if you or your covered dependent experiences one of six covered medical conditions
Long-term care insurance	Coverage to help pay for services required by those who need long-term care, which is the type of care that might be necessary for someone with an ongoing illness or disability
Financial Benefits	
Reimbursement accounts	Pre-tax payroll deductions fund tax-advantaged reimbursement accounts and/or a health savings account that reimburse you for qualified health care and/or child/elder care
Legal plan	Assistance for a range of commonly needed legal services

## Medical Benefits

Choice is a central part of the medical care provided through The Flexible Benefits Plan. For your medical coverage, you may enroll in either the Traditional option or the Healthy Savings option. Additional choices are indicated on your enrollment worksheet, and are based on whether your home address is within the service area of the medical PPO network designated for your state.

<i><b>If you live...</b></i>	<i><b>You can choose...</b></i>
Within a medical Preferred Provider Organization (PPO) network area only	<ul style="list-style-type: none"> <li>• Traditional PPO</li> <li>• Healthy Savings PPO</li> </ul>
Within a Health Maintenance Organization (HMO) network area (California or Hawaii only)	<ul style="list-style-type: none"> <li>• Kaiser HMO</li> <li>• Traditional PPO (or Out-of-Area)</li> <li>• Healthy Savings PPO (or Out-of-Area)</li> </ul>
Within both a PPO and an HMO network area (California or Hawaii only)	<ul style="list-style-type: none"> <li>• Traditional PPO</li> <li>• Healthy Savings PPO</li> <li>• Kaiser HMO</li> </ul>
Outside any network area	<ul style="list-style-type: none"> <li>• Traditional Out-of-Area</li> <li>• Healthy Savings Out-of-Area</li> </ul> <p>You may also choose to "opt in" to either the Traditional PPO or Healthy Savings PPO, if you find the PPO network providers are convenient to you.</p>

## Member Services

Member Services is your link to additional information regarding your medical care. You can call a Member Services representative to:

- Obtain information about a network physician's credentials
- Ask questions about your medical benefits or a medical service\*
- Replace a medical ID card

Your medical ID card will include a toll-free number for Member Services. Or, you can call the Benefits Service Center at 1-800-UPS-1508 to be transferred to Member Services.

*\*If the information provided by Member Services conflicts with the information in this booklet, the terms of this booklet control.*

## Guide to PPO (In-Network and Out-of-Network) Benefits

### ***What is a Preferred Provider Organization (PPO)?***

If you participate in a PPO option, you and your family can enjoy the benefits of network-based care. In a PPO network, you can choose to see providers participating in the network. You can also choose to use out-of-network providers, but your coverage will be different. The choice is yours each time you seek care.

<b>When Services are Provided In-Network</b>	<b>When Services are Provided Out-of-Network</b>
Coverage is provided at a higher level for most eligible charges	You pay a higher percentage of charges
Preventive medical care is covered	Preventive medical care is not covered
Your providers handle preauthorization for all hospitalizations	You are responsible for preauthorization for all hospitalizations
In-network care is provided at a negotiated rate and is not subject to reasonable and customary limits	You are responsible for charges above reasonable and customary limits
You don't have to file claim forms	You may be required to file claim forms

Primary care physicians, as well as other providers in the network — like hospitals, labs and x-ray facilities — are selected by the claims administrator based on reputation in the community, geographic location, efficiency in providing medical service, the quality of those services, and willingness to adhere to the claims administrator's guidelines and to provide appropriate, affordable care.

### Using a Primary Care Physician

In a PPO medical option, you don't have to designate a primary care physician. However, you should consider using a primary doctor on a regular basis, for yourself and your family, who will have a full knowledge of your health history. Your primary doctor can work with you in coordinating your care and finding the right specialists, if necessary.

### If a Network Provider is Not Available

In the rare instance that you are required to see a specialist or use a facility that is not in the PPO network, you or your physician can request the claims administrator's approval in advance. If approved, you will receive in-network benefits for the charges incurred with the out-of-network provider(s). Except for emergencies, the claims administrator must approve the use of out-of-network providers and facilities in advance, or out-of-network benefits will apply.

### If You Live Outside the PPO Network Area

If your home address is outside the PPO network and there are network providers in your state that you find convenient, you may "opt in" to the network and receive in-network benefits. See the *Enrollment* section of this booklet for information about when and how to opt into a medical network.

## Medical Options

The medical options available under The Flexible Benefits Plan are described below. Review the *Glossary of Benefit Terms* in the *Overview of the Plan* section for definitions of terms. See the *Summary of Benefits* section for the annual deductible and out-of-pocket maximum amounts, as well as the in-network and out-of-network benefit levels for covered expenses.

If you receive eligible out-of-network care, only the amounts within the reasonable and customary (R&C) limits are considered covered expenses. So the deductible, the out-of-pocket maximum and the Plan's coinsurance are all based on the R&C amount. All amounts in excess of the R&C limits are not covered by the Plan (even if the expense would otherwise be eligible) and do not apply toward any applicable deductible or out-of-pocket maximum.

*Amounts applied toward your in-network annual deductible and out-of-pocket maximums don't count toward your out-of-network deductibles and out-of-pocket maximums, and vice versa. So you'll save money two ways when you use only in-network providers — because fees are discounted and because you'll reach your deductible and out-of-pocket maximum sooner.*

## Medical Benefits (cont.)

### Traditional Medical Option — PPO or Out-of-Area

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#### ***Before the Annual Deductible is Met***

In the Traditional medical option, covered expenses not considered preventive care are applied to the annual deductible and annual out-of-pocket maximum. You pay out-of-pocket for these expenses until the annual deductible has been met. The annual deductible calculation includes eligible medical and behavioral health expenses.

Medical expenses considered preventive care are paid at 100 percent, and are not applied to the deductible or annual out-of-pocket maximum.

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#### ***When the Annual Deductible is Met***

In the Traditional medical option, both single and family deductibles apply to your coverage. This means that, when expenses incurred by one of your covered family members satisfy the single deductible, he or she begins receiving benefits at the coinsurance level for the remainder of the year.

If expenses incurred by two or more covered members of your family together satisfy the family deductible, all members of your family begin receiving benefits at the coinsurance level for the remainder of that calendar year, even if they haven't met the single deductible.

If you receive services from both in- and out-of-network providers, the in- and out-of-network deductibles **do not** cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual deductible does not also apply toward meeting your out-of-network annual deductible, and vice versa.

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#### ***When the Annual Out-of-Pocket Maximum is Met***

In the Traditional medical option, both single and family out-of-pocket maximums apply to your coverage. This means that, when covered out-of-pocket expenses incurred by one of your family members reach the single out-of-pocket maximum, all covered medical expenses he or she incurs for the remainder of the year are paid at 100 percent, within the limits of the Plan. The annual out-of-pocket maximum calculation includes eligible medical and behavioral health expenses.

If the family out-of-pocket maximum is reached by two or more covered members of the family, covered medical and behavioral health expenses incurred through the end of that calendar year by all family members are paid at 100 percent, within the limits of the Plan.

If you receive services from both in- and out-of-network providers, the in- and out-of-network out-of-pocket maximums **do not** cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual out-of-pocket maximum does not also apply toward meeting your out-of-network annual out-of-pocket maximum, and vice versa.

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#### ***Health Care Spending Account***

Employees who enroll in the Traditional medical option can elect to contribute to a Health Care Spending Account (HCSA) with pre-tax dollars to pay for out-of-pocket medical, dental and vision expenses. See the *Tax-Advantaged Reimbursement Accounts* section of this booklet for more information.

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## Healthy Savings Medical Option — PPO or Out-of-Area

**Before the Annual Deductible is Met** In the Healthy Savings medical option, covered expenses not considered preventive care are applied to both the annual deductible and annual out-of-pocket maximum. You pay out-of-pocket for these expenses until the annual deductible has been met. The annual deductible calculation includes eligible medical, behavioral health and prescription drug expenses.

Expenses considered preventive medical care are paid at 100 percent, and are not applied to the deductible or annual out-of-pocket maximum. The deductible is also waived for prescription drugs considered preventive care medications; however, the applicable coinsurance benefit is applied.

**When the Annual Deductible is Met** In the Healthy Savings medical option, either the single or family deductible applies to your coverage:

- If you elect coverage for only yourself, the single deductible applies to you.
- If you elect coverage for yourself and at least one other person, the single deductible **does not** apply to your coverage. Instead, the **family** deductible must be met before any member of your family begins receiving benefits at the coinsurance level for the remainder of that calendar year.

If you receive services from both in- and out-of-network providers, the in- and out-of-network deductibles **do not** cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual deductible does not also apply toward meeting your out-of-network annual deductible, and vice versa.

**When the Annual Out-of-Pocket Maximum is Met** In the Healthy Savings medical option, either the single or family annual out-of-pocket maximum applies to your coverage:

- If you elect coverage for only yourself, the single out-of-pocket maximum applies to you.
- If you elect coverage for yourself and at least one other person, the single out-of-pocket maximum **does not** apply to your coverage. Instead, the **family** out-of-pocket maximum must be met before covered expenses incurred by any member of your family for the remainder of the year are paid at 100 percent, within the limits of the Plan.

The annual out-of-pocket maximum calculation includes eligible medical, behavioral health and prescription drug expenses.

If you receive services from both in- and out-of-network providers, the in- and out-of-network out-of-pocket maximums **do not** cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual out-of-pocket maximum does not also apply toward meeting your out-of-network annual out-of-pocket maximum, and vice versa.

**Health Care Accounts** Participants in the Healthy Savings medical option have two opportunities to pay for out-of-pocket health care expenses with one or both of these tax-advantaged accounts:

- Limited Purpose Spending Account (LPSA) — reimbursement for eligible dental and vision expenses only (see the *Tax-Advantaged Reimbursement Accounts* section)
- Health savings account (HSA) that you establish with an approved financial institution – helps pay for medical, dental, vision and prescription drug expenses (see *What is an HSA?* in this section)

*The Healthy Savings medical option is specifically designed to work with an HSA to help maximize your tax savings. You must be covered by a qualified health plan in order to contribute to an HSA. All design features of the Healthy Savings option, such as the annual deductible and out-of-pocket maximums, comply with all Internal Revenue Service rules regarding high-deductible health plans.*

## Medical Benefits (cont.)

### *What is an HSA?*

A health savings account (HSA) is an individually owned account that can help you save on taxes while paying for health care expenses. You can establish and contribute to an HSA with OptumHealth Bank, the HSA vendor with whom UPS has partnered, or with another qualifying financial institution of your choice. You can make after-tax contributions toward your HSA and then take the deduction from your annual income tax return. If your HSA is with OptumHealth Bank, you can also have pre-tax payroll deductions automatically deposited into your HSA account. You may also choose to invest certain amounts of your HSA account funds. Any investment earnings are not taxed as long as they are used for qualified medical expenses. The amount you can contribute depends on whether you elect single or family coverage, and the maximum amount is subject to annual Internal Revenue Service (IRS) guidelines.

You can use your HSA to pay for eligible medical, dental, vision and prescription drug expenses. If you don't use all the money in your HSA during the year, your balance carries over to the next year and can be another way to save for future medical expenses.

You can contribute to an HSA as long as you are an "eligible individual," as defined by the IRS. If you become eligible for Medicare, you are not automatically disqualified from contributing to an HSA. However, if you elect to enroll in Medicare, you are no longer an eligible individual and may no longer contribute to your HSA.

There are no age limitations on when you must spend your account balance. If you retire or leave UPS, you take the account and the funds with you.

If you open an HSA with OptumHealth Bank and elect to contribute to your HSA on a pre-tax basis through payroll deductions, it is your responsibility to ensure that any after-tax contributions you make, combined with your pre-tax contributions, do not exceed the applicable annual maximum.

While an HSA gives you more control of how you spend your health care dollars, it requires careful planning and an understanding of complex rules. An HSA may require you to make more financial and budgeting decisions. Each time you incur an eligible expense, you'll decide whether to pay that expense out of your pocket or use funds from your health savings account.

The HSA is not maintained or sponsored by UPS and is not subject to ERISA.

If you elect to contribute to an HSA at OptumHealth Bank via payroll deductions, up to once a month you may change the amount you elect to contribute by calling the Benefits Service Center at 1-800-UPS-1508. The effective date of your change depends on your payroll frequency and the timing of data file transfers. Your request will be processed as soon as reasonably possible, but it could take up to a month or longer before the new amount is deducted from your paychecks.

### *Health Maintenance Organization (HMO) Option*

For employees who live in California or Hawaii only, The Flexible Benefits Plan provides a Kaiser Permanente HMO option in addition to the other medical options. If you live in one of these HMO areas, you will receive benefit information describing this additional option.



An HMO provides coverage only within its own network. There is usually no out-of-network benefit. In return, the HMO can be an easier, less complicated system to use. Here are some highlights of the HMO option. Note that medical, behavioral health and prescription drug benefits are provided by the Kaiser HMO, not by the other claims administrators described in this booklet. Refer to your HMO materials for complete details.

- **Your care is coordinated.** When you select the HMO option, you agree to receive care only from doctors affiliated with the HMO or to whom the HMO refers you. You may find it necessary to change doctors when you join the HMO if your doctor is not part of the network. But you receive higher benefits and may pay lower out-of-pocket expenses for most HMO network care.
- **It's all handled for you.** Your primary care physician (PCP) provides for your health care, orders tests, prescribes medicine and refers you to specialists. If you require hospitalization, your PCP arranges for admission and coordinates your hospital care.
- **Network referrals.** HMO network doctors have referral systems and integrated relationships with other providers, who work together for your benefit.
- **One-stop shopping.** HMOs provide primary and specialty care as well as pharmacy, lab and diagnostic services in one facility. Centralized and online medical records are available from all network facilities.
- **24-hour care.** An HMO doctor is “on call” around the clock, seven days a week. You’re always covered for emergencies and urgent care no matter where you travel.
- **Behavioral health and substance abuse care.** Refer to the Kaiser HMO materials for details about how mental health and substance abuse care are covered.
- **Prescription drugs.** Your HMO administers the prescription drug program. Check your HMO materials for coverage details.
- **No claim forms.** The HMO processes most paperwork for you and pays the doctors and specialists who treat you.
- **Seeking care outside the HMO.** Because only care received through the HMO is covered, special rules apply when you must seek care outside the HMO — for example, when you have an emergency or are traveling. Refer to the HMO literature or call Member Services for more information.
- **If your dependent(s) don't live with you.** Except for an emergency, HMO coverage is usually available only if you or your dependents receive care through the network. If your eligible dependents live outside the HMO network area (such as away at college), coverage is usually only available if those individuals come to the network area for care. If emergency care is provided out of the network area, the HMO usually limits follow-up care benefits outside the network area. Refer to your HMO materials for details, or call Kaiser Member Services for more information. Make sure you know the rules before selecting the HMO option.



## Medical Benefits (cont.)

*If you are enrolled in an HMO option (for California and Hawaii residents only), your coverage could be different. Refer to your HMO materials for details about your coverage, or contact your HMO Member Services.*

### What is Covered by Your Medical Benefits

Listed in alphabetical order below are the types of medical services and supplies covered by The Flexible Benefits Plan. The amount of covered charges the Plan will pay depends on the medical option you selected, as well as whether you seek care from an in-network or out-of-network provider. In all cases, in order for benefits to be paid by the Plan, the care must be determined by the claims administrator to be:

- Medically necessary
- Neither investigational nor experimental
- Within the standards for the reasonable and customary amount, and
- Not excluded by the Plan

**This list may not be all-inclusive.** If you're unsure whether a medical expense is generally covered\* by the Plan, contact your claims administrator's Member Services.

*\*Whether or not a covered service or treatment is paid by the Plan is based on the applicable facts and circumstances, and the applicable medical documentation supporting your claim.*

### Allergy Treatment

Allergy testing and treatments (including injections) are covered at the applicable coinsurance level.

### Ambulance (Ground or Air)

Use of an ambulance is covered when related to an emergency, or to a non-emergency when determined by the claims administrator to be medically necessary. Your out-of-pocket costs may be higher when you use an ambulance for a non-emergency. If you use an ambulance when not medically necessary, no benefits are provided. See the *Summary of Benefits* section for more information.

### Case Management

While none of us likes to think about a complicated, long-term illness or serious

accident, sometimes it can happen. Your medical claims administrator may offer a case management program for certain medical conditions, to help you and your dependents with:

- Understanding treatment plans and alternatives
- Monitoring claims payments
- Evaluating alternative treatment facilities and options

Call Member Services to discuss whether case management is appropriate for your situation. Early identification allows the patient, family, physician, social worker and/or case manager to work together to arrange appropriate care in a timely manner.

### Chiropractic Treatment

All medically necessary services performed or directed by a licensed chiropractor are covered at the applicable coinsurance level. Chiropractor visits (consisting of an office visit, manipulation, physical therapy and/or other related services) are limited to up to 60 visits per calendar year, regardless of whether you see an in-network or out-of-network chiropractor.

### Contraceptives

Prescription contraceptive devices, implants and injections are covered at the applicable coinsurance level.

### Expenses Not Covered

Over-the-counter contraceptive devices.

### Emergency Treatment

In an emergency, seek medical care as quickly as possible at the nearest appropriate facility. For a definition of an emergency, see the *Glossary of Benefit Terms* in the *Overview of the Plan* section.

## Emergency Rooms

Emergency rooms should be used only for true emergencies. (See *Glossary of Benefit Terms* in the *Overview of the Plan* section.) Your benefit will depend on whether the condition is an emergency medical condition as determined by the claims administrator. Once you are discharged from the emergency room or admitted to the hospital from the emergency room, emergency coverage ends and benefits are covered as non-emergency treatment.

If you receive medically necessary care for a non-emergency at an emergency facility, your out-of-pocket costs may be higher. See the *Summary of Benefits* section for more information.

## Home Health Care

Charges made by a home health agency for a covered family member in your home in accordance with a home health care plan are covered by this benefit. For these expenses to be eligible, the home health care plan must be outlined by your physician. It may be necessary for this treatment plan to be submitted to the claims administrator for review prior to or during treatment.

Home health care benefits are calculated on a per-visit basis. Each visit of up to four hours by a nurse, therapist or aide is considered one visit. There are no limits on the number of home health care visits when the service is provided in-network. Up to 120 home health care visits per calendar year are covered by the Plan for services incurred with out-of-network providers or by participants in an out-of-area medical option, as indicated in the *Summary of Benefits* section.

## Covered Expenses

- Part-time or intermittent home health aide services, consisting primarily of caring for the patient in conjunction with skilled nursing care

- Physical, occupational or speech therapy
- Drugs and most medical supplies prescribed by a physician
- Laboratory services

## Expenses Not Covered

- Services or supplies not included in the home health care plan outlined by your physician
- Services of a person who ordinarily lives in your home or who is a member of your family or your spouse's family
- Custodial care
- Transportation

## Hospice Care

Hospice care provides terminally ill patients and their families with an alternative to hospital care while assuring them of a specialized program tailored to each individual. Terminally ill patients require specialized care, both medical and psychological, that may not be readily available from the regular hospital staff. For purposes of this program, a terminally ill patient has a medical prognosis of six months or less to live.

## Covered Expenses — Inpatient

Charges for room and board made by a hospice facility, hospital, convalescent facility or physician are allowable when furnished on a full-time inpatient basis for pain control and other acute and chronic symptom management.

There are no limits to the number of days of inpatient hospice care if provided in-network. Up to 30 days of inpatient hospice care are covered by the Plan for services incurred with out-of-network providers or by participants in an out-of-area medical option. Any in-network days will be counted toward your out-of-network limit, as indicated in the *Summary of Benefits* section.

## Medical Benefits (cont.)

### Covered Expenses — Outpatient

The following services and supplies are allowable when furnished to a person receiving outpatient hospice care coordinated by the hospice program administrator:

- Part-time intermittent nursing care by an RN or LPN for up to eight hours in any one day
- Medical social services under the direction of a physician, including assessment of the person's social, emotional and medical needs, and of the home and family situation
- Identification of community resources needed to meet his or her assessed needs, including assisting the person to obtain the resources needed to meet his or her assessed needs
- Psychological and dietary counseling
- Consultation or case management services by a physician or nurse
- Physical therapy
- Part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person

There are no limits to the number of days of outpatient hospice care if provided in-network. Up to \$5,000 in expenses for outpatient hospice care provided by an out-of-network provider or by participants in an out-of-area medical option. If you use both in-network and out-of network providers, any in-network visits will be counted toward your out-of-network limit.

### Expenses Not Covered

- Any charge for daily room and board in a private room in excess of the facility's semiprivate room rate
- Charges made for the following services:
  - Bereavement counseling
  - Funeral arrangements
  - Pastoral counseling

- Financial or legal counseling, including estate planning or the drafting of a will
- Homemaker or caregiver services that are not solely related to care of the person (such as sitter or companion services for the patient or other members of the family, transportation, house-cleaning and maintenance of the house)
- Respite care

## Hospitalization

### Inpatient Services

- Semiprivate room and board and related services and supplies
- The use of operating, recovery and treatment rooms and their equipment
- The use of intensive care and cardiac care units
- Dressings, splints and plaster casts
- Inpatient laboratory and x-rays
- Physical therapy
- Electrocardiograms
- Oxygen and anesthesia and their administration
- The cost and administration of blood and blood plasma
- Intravenous injections and solutions
- X-ray and radium therapy
- Prescribed drugs

### Inpatient Alternatives

Rather than a stay as a hospital inpatient, an alternative course of medical care may be more appropriate, cost-effective and comfortable. Expenses may be covered for a skilled nursing facility, private duty nursing (outpatient), home health care and hospice care. The individual alternatives and benefits available for each are listed separately in this section.

### Outpatient Services

The Flexible Benefits Plan covers outpatient hospital services provided on an outpatient basis or by a licensed free-standing emergency care center, surgical center or birthing center:

- Preadmission testing within seven days of a scheduled admission for non-emergency surgery
- Chemotherapy infusion
- Kidney dialysis performed either in the hospital or your home
- Hospital charges connected with outpatient surgery
- Hospital emergency room care of an accidental injury or for emergency treatment of a life-threatening sudden and serious illness

### Expenses Not Covered

- Additional expenses for a private room in a hospital, unless medically necessary
- Hospital care for diagnostic purposes, unless the covered person's condition or type of test requires hospitalization

### Infertility Treatment

The Flexible Benefits Plan covers charges for the diagnosis of the cause of infertility and/or medical treatment to correct that cause. Both men and women are covered for infertility treatment.

Because of the variety of treatment approaches to infertility, you or your doctor may want to contact your claims administrator before treatment begins to determine whether a particular treatment will be covered.

See the *Prescription Drug Benefits* section for details on how infertility medications are covered.

### Expenses Not Covered

The following procedures are not covered by the Plan because they do not correct the underlying medical causes of infertility:

- Intrafallopian transfer
- Sperm banking/semen specimen storage
- Drugs for sexual dysfunction
- Reversal of voluntary sterilization
- Procedures, services (including lab and x-ray) or supplies intended to induce pregnancy rather than treat an underlying medical cause; such as:
  - Artificially assisted insemination (including related counseling)
  - In vitro fertilization
  - Embryo transfer procedures
  - Surrogate parenting

### Maternity Services

Maternity services are covered, just as any other condition requiring medical treatment.

Covered services include:

- Normal delivery or delivery by cesarean section
- Prenatal and postnatal care
- Initial sonogram per pregnancy
- Additional sonograms only if medically necessary
- Amniocentesis if medically necessary
- Treatment by an obstetrician for complications during pregnancy and delivery
- Services in connection with a miscarriage or abortion (including a voluntary abortion)
- Surgery related to an extrauterine or ectopic pregnancy
- Lamaze or other child-birth preparation classes (upon completion of the class)
- Services of a registered midwife when delivery is performed in a hospital, licensed free-standing emergency care center or birthing center

## Medical Benefits (cont.)

### Length of Hospital Stay

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Medical Supplies and Equipment

Coverage includes the medical supplies listed below. Call your claims administrator's Member Services to determine whether a medical supply not listed is covered.

- Rental or purchase of durable medical equipment required for therapeutic use and prescribed by a physician. Durable medical and surgical equipment is equipment made to withstand prolonged use, made for and mainly used in the treatment of a disease or injury, suited for use in the home, not normally of use to persons who do not have a disease or injury, not for use in altering air quality or temperature and not for exercise or training. In determining the maximum amount that will be paid for durable medical equipment, the claims administrator will consider the appropriateness of the equipment based on your medical needs and suitable alternatives. To determine whether rental or purchase is appropriate, call Member Services at the number on your medical ID card
- The purchase of artificial limbs or other prosthetic appliances

- Medical supplies and dressings prescribed by a physician, including splints, trusses, braces, catheters, oxygen and equipment for its administration, blood and blood products, electronic pacemaker and colostomy bags and colostomy-related supplies and PKU supplements

### Expenses Not Covered

- Hearing aid repairs
- Expenses related to the purchase of orthopedic shoes or related corrective devices and appliances, except where the shoes or devices are permanently fastened to an orthopedic brace and are medically necessary or used in the place of surgery
- Personal hygiene or convenience items, such as air conditioners, humidifiers and physical fitness equipment
- Items to accommodate your home, office or vehicle as a result of an injury or illness, such as wheelchair lifts, hand rails, or stair risers

### Podiatrist Treatment

All medically necessary services performed or directed by a licensed podiatrist are covered at the applicable coinsurance level. Podiatrist visits are limited to up to 60 visits per calendar year, regardless of whether you see an in-network or out-of-network podiatrist.

### Preventive Care

The Plan pays for services for preventive medical care provided on an outpatient basis. Preventive care services are provided solely for the purpose of preventing an illness that has not yet been diagnosed, not to treat an existing illness or injury. In determining how frequently certain preventive care services are covered for your age and gender, the medical claims administrators carefully follow various guidelines for what is considered preventive care, such as those published by the U.S. Preventive Services Task Force, the American Medical



Association, the American Academy of Pediatrics and the IRS safe harbor guidelines.

If testing is done for a medical diagnosis or to monitor or prevent complications from an existing condition, it is not considered preventive care. Also, if you are diagnosed with a condition during your preventive care visit that results in non-preventive care being rendered, charges associated with your non-preventive care will not be considered preventive care and applicable benefits will be applied.

For a summary of covered preventive care services, see *Preventive Medical Care Guidelines* in this section. This list is intended as a general guideline for your physician. It is not a complete list of preventive services covered by the Plan, as some preventive services are only administered in certain situations. If you're not sure whether a specific service will be covered as preventive care, you or your doctor should contact your medical claims administrator, before services are rendered, at the toll-free number that appears on your medical ID card, or call 1-800-UPS-1508 to be connected to Member Services.

Preventive care is only covered when performed by an in-network physician or if you are in the out-of-area medical option. There is **no** coverage for preventive care services provided by an out-of-network provider.

For benefit levels, see *Medical* in the *Summary of Benefits* section.

### ***Private Duty Nursing (Outpatient)***

Benefits are payable for medically skilled, private duty nursing at your home if your doctor prescribes it. Benefits cover the home services of registered nurses, licensed practical nurses and licensed vocational nurses, up to a maximum of 560 hours per calendar year (the equivalent of 70 eight-hour shifts). The 560 hours are counted

as they are used. For example, a two-hour visit will be counted as two hours, rather than an eight-hour shift. Call the toll-free number on your medical identification card before you make any arrangements for outpatient private duty nursing.

To be covered, outpatient private duty nursing services must:

- Be medically necessary for treatment of a disease or injury
- Require the medical training and technical skills of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN), and
- Be ordered by the attending physician as necessary treatment

It's important to understand that, while skilled nursing care may be necessary initially, alternate caregivers may be encouraged to learn the skills necessary for ongoing medical care. Once alternate caregivers have demonstrated their proficiency in a particular procedure, skilled nursing coverage for that procedure may cease.

### **Expenses Not Covered**

- Private duty nursing in a hospital. The hospital provides a staff of registered nurses for care given during hospitalization; this service is included in the room and board charges
- Custodial care, even if given by an RN, LPN or LVN. Custodial care includes such things as meal preparation, bathing the patient, acting as a companion and other services that may be necessary for the normal activities of daily living, but that do not require the medical training and technical skills of a nurse. Daily nursing notes will be reviewed to determine the portion of the nursing care expenses that qualifies for benefits
- Services provided by a nurse who lives with you

*Call the toll-free number on your medical ID card before making arrangements for private duty nursing.*

## Medical Benefits (cont.)

*If you are enrolled in the HMO option (California or Hawaii only), your coverage may be different. Refer to your HMO materials for details, or call your HMO Member Services.*

### Professional Services

Coverage under the Plan is provided for the following professional services:

- Doctor's and osteopath's services
- Second surgical opinions
- Chiropractor's services (limited to 60 visits per calendar year)
- Podiatrist's services (limited to 60 visits per calendar year)
- Services by a registered graduate nurse, licensed practical nurse or licensed vocational nurse
- Examinations and other services for the treatment of an illness or injury, including radiation therapy and chemotherapy
- Medical consultations when requested by the physician in charge of the patient
- Diagnostic examinations, x-rays and laboratory tests, including their reading and interpretation
- Charges for hearing exams and an initial hearing aid per ear per lifetime age 19 or older; or one hearing aid per ear every three years for children up to age 19 when prescribed by an otolaryngologist
- Ambulance service to the nearest appropriate facility to treat a patient's medical condition
- Hemodialysis

### Reconstructive Surgery Following a Mastectomy

The following services are covered. Benefits are paid as for any other covered service:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient

### Rehabilitation Therapy (Short-Term)

Charges made by a physician or a licensed or certified physical or occupational therapist for furnishing short-term rehabilitation services for the treatment of acute conditions are covered. Short-term rehabilitation therapy is physical therapy or occupational therapy for the improvement of a body function that has been lost or impaired due to injury or illness.

### Expenses Not Covered

- Services and supplies received while you or your dependent are confined in a hospital or other facility for medical care (these may be covered by other Plan provisions)
- Services not performed by or under the direct supervision of a physician
- Services not provided in accordance with a specific treatment plan that:
  - Details the treatment to be given and the frequency and duration of the treatment, and
  - Provides for ongoing reviews and is renewed only if therapy is still necessary
- Services or supplies covered to any extent by any other part of The Flexible Benefits Plan, or any other group plan sponsored by UPS

There is no limit to the number of medically necessary visits for rehabilitation care provided in-network. If you choose out-of-network care, you are limited to 60 visits (combined rehabilitation and speech therapy) per calendar year. If you participate in an out-of-area option, you are limited to 90 combined visits per calendar year. Any in-network visits will be counted toward your out-of-network limit.

In any case, you must show improvement within 60 calendar days from the beginning of treatment for coverage to continue.

### ***Skilled Nursing Facility***

Skilled nursing facilities provide intermediate care following a hospital stay, when a patient may continue to require 24-hour nursing care for a limited period, but not at the level of care provided by a hospital. In these circumstances, benefits for a skilled nursing facility (or convalescent care facility) will be paid by the Plan.

There is no limit to the number of days of skilled nursing facility care if provided in-network. Up to 60 days per calendar year are covered when you choose an out-of-network skilled nursing facility or participate in an out-of-area option. Any in-network days will be counted toward your out-of-network limit.

### ***Speech Therapy***

Benefits are paid for speech therapy only when needed to restore speech lost as a result of an illness or injury. For example, children who have not fully developed their speech skills (in other words, as a result of developmental delays) are not eligible for these restorative services. However, someone who loses speech capacity as a result of an accident could receive benefits under this provision.

Speech problems can be unique, varying in severity from individual to individual, and frequently diagnoses can be subjective. To help determine whether the condition is covered by the Plan and what benefits may be payable, you and/or your provider should consider submitting detailed information to the claims administrator for review before incurring expenses.

To be eligible for benefits, treatment of a speech problem must be prescribed, controlled and directed by a doctor and approved by the claims administrator.

There is no limit to the number of medically necessary visits provided in-network. If you choose out-of-network care, you are limited to 60 visits (combined

rehabilitation and speech therapy) per calendar year. If you participate in an out-of-area option, you are limited to 90 combined visits per calendar year. Any in-network days will be counted toward your out-of-network limit.

In any case, you must show improvement within 60 calendar days from the beginning of treatment for coverage to continue.

### **Expenses Not Covered**

Besides the exclusions noted in *What is Not Covered by Your Medical Benefits* in this section, the following conditions and services are not covered by the Plan.

- Certain speech problems, such as stuttering in children, may be covered by Public Law 94-142, The Education for All Handicapped Children Act of 1975. This law provides public schools with language and speech services for all children between the ages of three and 21, including help in identifying and diagnosing speech and language disorders as well as rehabilitative and preventive treatment. As a result, these types of speech problems are not covered
- Certain speech problems in children that are classified as developmental delays
- Services rendered for the treatment of delays in speech development, unless to restore speech lost as a result from injury or illness
- Speech problems caused by learning disabilities or articulation disorders (although any underlying psychological reason for the condition may be covered as a mental or nervous disorder)
- Services or supplies that a school system is required by law to provide
- Services of a speech therapist who lives in your home
- Special education, including lessons in sign language, to teach a covered person whose ability to speak has been lost or impaired to function without that ability



## Medical Benefits (cont.)

### *Surgical Services*

Covered surgical services under the Plan include pre-operative and post-operative care within the 14-day period after surgery. These include services by a:

- Surgeon
- Anesthesiologist
- Assistant surgeon when medically necessary or when required by the hospital's established policy

### **Coordinating with Dental Coverage**

If you need dental surgery that requires hospitalization, the dentist's charges are covered by the dental component of The Flexible Benefits Plan. Other eligible charges are covered by the medical component of the Plan. Please contact your medical claims administrator for more information.

### **Expenses Not Covered**

- Plastic surgery, reconstructive surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. However, benefits are paid if cosmetic/plastic surgery is needed to:
  - Improve the function of a body part that is not a tooth or structure that supports the teeth
  - Correct a severe birth defect, including cleft lip or palate or webbed fingers or toes, provided the surgery is necessary to improve the functionality of the body part, or
  - Correct a malformation as a direct result of disease, surgery performed to treat a disease (including reconstructive surgery following a mastectomy), or an accidental injury

- Services or supplies related to any eye surgery mainly to correct refractive errors (for example, radial keratotomy) unless vision acuity cannot be corrected to 20/50 with corrective lenses

### **Total Parenteral Nutrition and Enteral Nutrition**

Total parenteral nutrition (TPN) is required for patients with certain medical conditions that impair gastrointestinal function to a degree incompatible with life or with optimal recovery from interventional procedures, such as major surgery or cancer chemotherapy. These patients cannot be maintained through oral feeding and must rely on parenteral nutritional therapy for prolonged periods of time.

Enteral nutrition (EN) is considered necessary for a patient with a functioning gastrointestinal tract who:

- Experiences dysfunction of surrounding structures that are necessary to permit food to reach the gastrointestinal tract, and
- Cannot maintain weight or strength commensurate with his or her general condition.

Examples of these conditions are head and neck cancer with reconstructive surgery, and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion.

In order to qualify for this coverage, the patient must:

- Require at least 75 percent of their total sustenance from EN or TPN, and
- Have a long-term need for EN or TPN, and
- Have a condition involving the GI tract which prevents adequate oral intake

### Covered Expenses

- Cost of nutrients/solutions, except baby food and other regular grocery items, including those that can be blended and used in enteral feeding systems
- Cost of the infusion pump and heparin lock
- Supplies and equipment necessary for proper functioning and effective use of a TPN or EN system
- Home visits by a physician or nurse in conjunction with TPN or EN

### Expenses Not Covered

- EN for patients with a normally functioning GI tract whose need for enteral nutrition is due to a lack of appetite or cognitive problems
- Standard infant formulas and formula and food products modified to be low protein for people with inherited diseases of amino acid and organic acid metabolism (except PKU)
- Baby food and other regular grocery items, including those that can be blended and used in enteral feeding systems

### Transplants

The Flexible Benefits Plan provides the same coverage for services and procedures related to transplants as for any other medical procedure.

Claims administrators develop nationwide transplant networks to coordinate available resources for transplant procedures. National transplant networks are created using a rigorous credentialing methodology. Facilities participating in the transplant networks have been evaluated for their surgical and medical capabilities as well as their clinical outcomes (how well they performed).

While you are not required to, you are encouraged to consider using a facility in your claims administrator's national transplant network. If you do, transportation costs as outlined below will be covered.

### Covered Expenses

- Expenses for lodging and transportation determined by your claims administrator to be reasonable and necessary incurred by the covered recipient and a companion who travels the same day(s) as the recipient to and from the transplant center for pre-transplant evaluation, transplant surgery and necessary post-transplant services performed at the transplant center
- If the covered recipient is a minor, transportation and lodging expenses for two companions who travel with the minor, as described above
- A daily maximum of \$200 and an overall lifetime maximum of \$15,000 for all transportation and lodging expenses incurred for covered services per transplant

### Expenses Not Covered

- Services rendered by a member of the recipient's, companion's or donor's immediate family
- Purchase or shipment of home furnishings or personal belongings

The Preventive Medical Care Guidelines are **not** a complete list of preventive care services covered by the Plan. For more information, call the Member Services number listed on your medical ID card.

## Medical Benefits (cont.)

### Preventive Medical Care Guidelines

This list is intended as a set of general guidelines for your physician. It is not a complete list of preventive medical care services covered by the Plan, as some preventive services are only administered in high-risk situations. If you're not sure whether a specific service will be covered as preventive care, you or your doctor should contact your medical claims administrator at the toll-free number that appears on your medical ID card, or call 1-800-UPS-1508 to be connected to Member Services.

#### Guidelines for Children

Age	Birth up to Age 1	Age 1 up to Age 3	Age 3 up to Age 7	Age 7 up to Age 20
<b>Visits</b>	7 well child	3 well child	1 well child	1 routine physical
<b>Frequency</b>	Every year	Every year	Every year	Every other year
<b>Immunizations</b>	Per current guidelines	Per current guidelines	Per current guidelines	Per current guidelines
<b>Tests</b>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• Hemoglobin and Hematocrit</li> <li>• Tuberculin skin test</li> <li>• PKU</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• Hemoglobin and Hematocrit</li> <li>• Tuberculin skin test</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• Hemoglobin and Hematocrit</li> <li>• Tuberculin skin test</li> <li>• Hearing screening</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• Hemoglobin and Hematocrit</li> <li>• Tuberculin skin test</li> </ul>
<b>Females only</b>	N/A	N/A	N/A	<ul style="list-style-type: none"> <li>• Gyn. exam every year 18 and older</li> <li>• Pap smear</li> <li>• Breast exam</li> </ul>
<b>Males only</b>	N/A	N/A	N/A	<ul style="list-style-type: none"> <li>• Testicular exam</li> </ul>

#### Guidelines for Adults

Age	Age 20 up to Age 30	Age 30 up to Age 40	Age 40 Up to Age 50	Age 50 and Older
<b>Visits</b>	1 routine physical	1 routine physical	1 routine physical	1 routine physical
<b>Frequency</b>	Every 24 months	Every 24 months	Every 24 months	Every year
<b>Immunizations</b>	<ul style="list-style-type: none"> <li>• DPT</li> <li>• MMR</li> </ul>	<ul style="list-style-type: none"> <li>• DPT</li> <li>• MMR</li> </ul>	<ul style="list-style-type: none"> <li>• DPT</li> <li>• MMR</li> </ul>	<ul style="list-style-type: none"> <li>• DPT</li> <li>• MMR</li> </ul>
<b>Tests</b>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• 12-lead EKG</li> <li>• Chest x-ray</li> <li>• SMA 18/22</li> <li>• CBC</li> <li>• Lipid profile</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• 12-lead EKG</li> <li>• Chest x-ray</li> <li>• SMA 18/22</li> <li>• CBC</li> <li>• Lipid profile</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• 12-lead EKG</li> <li>• Chest x-ray</li> <li>• SMA 18/22</li> <li>• CBC</li> <li>• Lipid profile</li> <li>• Occult blood</li> </ul>	<ul style="list-style-type: none"> <li>• Urinalysis</li> <li>• 12-lead EKG</li> <li>• Chest x-ray</li> <li>• SMA 18/22</li> <li>• CBC</li> <li>• Lipid profile</li> <li>• Occult blood</li> <li>• Exercise stress</li> </ul>
<b>Females only</b>	<ul style="list-style-type: none"> <li>• Gyn. exam every year 18 and older</li> <li>• Pap smear</li> <li>• Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>• Gyn. exam every year 18 and older</li> <li>• Pap smear</li> <li>• Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>• Gyn. exam every year 18 and older</li> <li>• Pap smear</li> <li>• Breast exam</li> </ul>	<ul style="list-style-type: none"> <li>• Gyn. exam every year 18 and older</li> <li>• Pap smear</li> <li>• Breast exam</li> </ul>
<b>Males only</b>	<ul style="list-style-type: none"> <li>• Testicular exam</li> </ul>	<ul style="list-style-type: none"> <li>• Testicular exam</li> </ul>	<ul style="list-style-type: none"> <li>• Testicular exam</li> <li>• PSA</li> </ul>	<ul style="list-style-type: none"> <li>• Testicular exam</li> <li>• PSA</li> </ul>

## What is Not Covered by Your Medical Benefits

In addition to the items specifically listed above as excluded, the following additional items are not covered.

- Services or treatment not specifically listed as covered
- Custodial care, rest centers, nursing homes or assisted living centers
- Dietary supplements, including any supplement for newborn infants, except as described in *Total Parenteral Nutrition and Enteral Nutrition* in this section and PKU supplements
- Services or supplies for or related to sex change surgery or any treatment of gender identity disorders
- Acupuncture therapy, except when acupuncture is performed by a physician as a form of anesthesia in connection with surgery that is covered by the medical option you select
- Weight reduction programs, unless pre-approved by the claims administrator
- Services, treatment, educational testing or training related to learning disabilities or developmental delays
- Care furnished mainly to provide surroundings free from exposure to conditions that can worsen a person's disease or injury
- Expenses listed as not covered in other subheadings in this section
- Services of a physician who is still a resident or intern, when services are billed in that capacity
- Charges for a missed or broken appointment
- Charges for a doctor's travel
- Services and supplies you are not legally obligated to pay for
- Administrative or office fees, such as copying and mailing expenses and state and local taxes
- Claims received by the claims administrator more than 12 months past the date of service
- Charges that exceed reasonable and customary limits, as determined by the claims administrator
- Services provided before coverage becomes effective or after coverage ends
- Services or supplies that are not determined by your claims administrator to be medically necessary; even if prescribed, recommended or approved by the attending physician or dentist
- Services or supplies the claims administrator determines to be unnecessary for the diagnosis, care or treatment of the condition involved
- Charges made only because coverage exists
- Care, treatment, services or supplies not prescribed, recommended and approved by the attending physician
- Services or supplies not provided in keeping with medical or professional standards and practice
- Treatments or procedures and related materials that are investigational or experimental in nature, as determined by the claims administrator
- Occupational conditions, ailments or injuries for which coverage is provided by Workers' Compensation or by a similar law

## Medical Benefits (cont.)

- Services and supplies provided by a personal injury protection or compulsory medical payments provision of any motor vehicle insurance contract required by federal or state law, whether or not the participant properly asserts his or her rights under the motor vehicle insurance contract
- Treatment of a condition caused by war (declared or undeclared) or any act of war
- Treatment of a condition caused by committing an unlawful act of aggression, including a misdemeanor or a felony
- Services or supplies for which benefits are provided by any government law, except as otherwise required by law
- Services or supplies that are provided by reason of past or present service in the armed forces of any government

## Maintenance of Benefits and Coordination with Medicare

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See *Maintenance of Benefits and Coordination with Medicare* in the *Filing a Claim* section of this booklet for more information.

## Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details.

## How to File a Medical Claim

See the *Filing a Claim* section of this booklet.

## Behavioral Health Benefits

When you or a covered family member needs help with a mental health or substance abuse problem, you can turn to a special UPS behavioral health program. The program provides confidential behavioral health counseling, treatment and referrals through a network of trained professionals. This coverage is included in your medical benefits and is subject to all medical annual deductibles and out-of-pocket maximums, as well as lifetime maximums.

Your behavioral health coverage is administered by ValueOptions. You don't need a referral from your medical doctor to take advantage of the program's services. Furthermore, the ValueOptions network is nationwide, so you can get the advice and care you need from a network provider, no matter where you live. To view a summary of your behavioral health benefits, see the *Summary of Benefits* section.

The Plan provides benefits for behavioral health treatment that is medically necessary. Medically necessary means care that, as determined by ValueOptions:

- Is appropriate and necessary to evaluate or treat a disease, condition or illness as defined by standard diagnostic nomenclatures (the American Psychiatric Association's Diagnostic and Statistical Manual IV as revised or updated in the future)
- Can reasonably be expected to improve an individual's condition or level of functioning
- Is in keeping with national standards of mental health professional practice as defined by standard clinical references and valid empirical experience for efficacy of therapies, and
- Is provided at the most appropriate and cost-effective level of care

### Member Services

ValueOptions' Member Services is your link to your behavioral health benefits. You can call a Member Services representative to:

- Discuss your situation in complete confidence
- Obtain a referral to a network provider for emergency or non-emergency care
- Verify that a non-network provider meets state licensing requirements
- Ask questions about your behavioral health benefits or a related service

You can contact ValueOptions toll-free 24 hours a day, 365 days a year, at 1-800-336-9117. Their number is also printed on the back of your medical ID card.

### Guide to In-Network Benefits

Through your behavioral health benefit, you and your family have access to the nationwide ValueOptions Network of behavioral health treatment professionals, programs and facilities, including the following.

- Psychiatrists (MD and DO)
- Licensed clinical psychologists (doctoral level)
- Licensed masters-level clinical social workers (for example, licensed MSW)
- Masters-prepared psychiatric registered nurses (for example, MA, MS, MSN)
- Masters-level psychologists
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Treatment clinics
- Hospitals

The providers in the network must meet strict membership requirements and have up-to-date credentials. They are regularly reviewed by ValueOptions to make sure they continually meet network membership standards.

*The behavioral health program complements, but does not replace, Solutions — Your EAP and Work/Life Benefit program.*

### Confidentiality

*Information regarding behavioral health benefits for you or an eligible dependent's mental health and/or substance abuse benefits will be kept confidential, except with your written consent or where disclosure is required by law or as otherwise set forth in the health plan privacy policies.*

## Behavioral Health Benefits (cont.)

All professionals in the network must be licensed at the highest level for their discipline in the state in which they are practicing and have at least three years of clinical experience in providing direct patient care. There are both male and female therapists, some of whom are multilingual.

When you first call ValueOptions, you'll talk with a masters-level clinician who will discuss your situation confidentially with you. You may then be referred to an appropriate provider for a more complete evaluation and development of a treatment plan. After a treatment plan is developed, ValueOptions will monitor the care to ensure the treatment you receive is appropriate and medically necessary.

### If You Use Out-of-Network Providers

If you choose to seek treatment outside the ValueOptions network, the provider must hold the highest level of licensure or certification offered by the state in which they are practicing. Because licensing requirements vary from state to state, it is best to call ValueOptions before you start treatment to verify that you are seeing an appropriate provider.

### What is Covered by Your Behavioral Health Benefits

You receive maximum benefits when you call ValueOptions for a referral. You can receive treatment through ValueOptions as a continuation of treatment started as part of the EAP or calling ValueOptions directly for emergency or non-emergency care.

If you seek emergency treatment, you must contact ValueOptions within 48 hours.

No preauthorization from ValueOptions is required for the first 10 visits of outpatient treatment per provider, per lifetime.

Covered outpatient treatment includes, but is not limited to:

- Individual, group, or family therapy
- Medication management

You **must** obtain preauthorization from ValueOptions for the following services, or no benefits are payable:

- All outpatient treatment beyond the first ten visits, per provider, per lifetime
- All inpatient treatment (including but not limited to partial hospitalization, intensive outpatient treatment and residential treatment)
- All substance abuse treatment
- Psychological testing
- Complex medication management
- Electroconvulsive therapy (ECT)
- Biofeedback
- Hypnotherapy
- Aversion therapy

### What is Not Covered by Your Behavioral Health Benefits

The following behavioral health services and treatments are not covered by the Plan:

- Court-ordered treatment, unless assessed and certified by ValueOptions to be in keeping with medically necessary standards
- Services and treatment for the purpose of maintaining employment or insurance, unless assessed and certified by ValueOptions to be in keeping with medically necessary standards
- Services and treatments that are:
  - Educational or vocational in nature
  - Required by law to be provided by a school system for a child (such as evaluation for attention deficit disorder)
  - For personal growth and development
  - For adjudication of marital, child support and custody cases



- Services and treatment that are experimental, investigational, mainly for research or not in keeping with national standards of practice as determined by ValueOptions; for example, treatment of sexual addiction, codependency or any other behavior that does not have a psychiatric diagnosis
- Regressive therapy, megavitamin therapy, nutritionally based therapies for chemical dependency treatment, and non-abstinence-based chemical dependency treatment (with the exception of medically necessary methadone maintenance or Suboxone® treatments)
- Custodial care, including, but not limited to, treatment not expected to reduce the disability to the extent necessary to enable the patient to function outside a protected, monitored or controlled environment
- Services and treatment for:
  - Mental retardation (except initial diagnosis)
  - Autism spectrum disorders (except initial diagnosis) that may be covered by the medical plan
  - Pervasive developmental disorders
  - Chronic organic brain syndrome
  - Learning disabilities
- Treatment for:
  - Transsexualism
  - Smoking cessation (see the *Quit For Life* section in this booklet for information about a separate benefit provided by The Flexible Benefits Plan)
  - Obesity and/or weight reduction
  - Stammering or stuttering
  - Chronic pain except for psychotherapy, biofeedback or hypnotherapy provided in connection with a psychiatric disorder
- Expenses listed as not covered in this section

In addition to this list, certain medical services or supplies are not covered (for a general list of what's not covered, see *What is Not Covered by Your Medical Plan* in the *Medical Benefits* section). To determine whether a specific mental health or substance abuse treatment will be covered, call ValueOptions at 1-800-336-9117.

## Maintenance of Benefits and Coordination with Medicare

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See *Maintenance of Benefits* and *Coordination with Medicare* in the *Filing a Claim* section for more information.

ValueOptions requires verification of other coverage once per year prior to paying any claims.

## Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details on the Plan's right of recovery provisions.

## How to File a Claim

See the *Filing a Claim* section of this booklet.



## Prescription Formulary

*To help contain the increasing cost of prescription drug coverage and continue the UPS commitment to quality care, your prescription drug benefit includes a formulary, also called a preferred brand list. A formulary is simply a list of commonly prescribed medications that have been selected by Medco because of their combination of effectiveness and cost.*

*The preferred brand list operates in conjunction with the Medco By Mail program. In addition, all participating retail pharmacies in the Medco prescription program will be aware of drugs currently on the formulary. Your doctor and non-participating pharmacies should call Medco toll-free at 1-800-346-1327 to learn which drugs are formulary drugs.*

*You should always encourage your physician to prescribe formulary drugs whenever a brand-name drug is necessary, because the cost of formulary drugs is lower and, as with all FDA-approved prescription drugs, their effectiveness has been established.*

## Prescription Drug Benefits

Prescription drug coverage is included in your medical benefits under The Flexible Benefits Plan. Benefits for participants in the medical PPO and out-of-area options are administered by Medco Health Solutions. The program gives you and your family two ways to save money on prescription medications:

- You may have your prescriptions filled at pharmacies that participate in the Medco retail pharmacy program
- You must order maintenance medications through the Medco By Mail program
- You receive benefits for specialty medications when you purchase them through Accredo, Medco's specialty pharmacy

When you enroll in medical benefits under the Plan, you receive a Medco ID card in addition to your medical ID card. Call Medco's Member Services at 1-800-346-1327 to request any additional ID cards.

## Three Levels of Coverage

Benefits for prescription drugs are paid at three levels, providing UPSers and their families high-quality medications that are effective and affordable.

- **Generic drugs** are proven safe and must meet the same U.S. Food and Drug Administration (FDA) standards for brand-name drugs. They have the same active ingredients as their brand versions, but are usually available at a lower cost
- **Preferred brands** are listed on the Medco prescription formulary. When a generic is not available, a preferred brand will cost less than a drug not on the formulary
- **Non-preferred brands and non-sedating antihistamines** are not on the formulary and are available at a higher cost. Prior authorization is required for most non-preferred brands

See the *Summary of Benefits* section of this booklet for the coverage provided for each level of drug.

## How Benefits Are Paid

Generally, the highest benefit under the Plan is paid for generic drugs, followed by brand-name drugs included on the preferred brand drug list, also called a formulary. The lowest level of benefits is paid for brand-name drugs that are not included on the preferred brand drug list. If your non-preferred brand drug requires prior authorization but none is obtained, no benefit is paid. You or your pharmacist can call Medco's Member Services at 1-800-346-1327 to find out whether a specific brand drug is considered non-preferred and whether prior authorization is required.

A per-script minimum and maximum out-of-pocket expense applies to most prescriptions. This is the minimum and maximum amount you are required to pay out-of-pocket for a covered prescription drug after the applicable coinsurance benefit is applied:

- If the cost of the drug is less than the minimum, you pay the full cost of the drug
- If the amount of your coinsurance is less than the minimum, you must pay the minimum amount
- If your coinsurance exceeds the maximum, you pay only the maximum amount

In all cases, if you purchase a brand-name drug when a generic is available, you **must** also pay the difference in cost between the brand and generic drug. This difference is not included in the per-script maximum or annual out-of-pocket maximum.

Additional provisions apply to how your prescription drug benefits are paid, depending on the medical option you selected.

### ***Under the Traditional Medical Option***

If you're enrolled in the Traditional PPO or Traditional Out-of-Area medical option, your prescription drugs are never applied toward your annual deductible — they are simply paid at the benefit levels shown in the *Summary of Benefits* section of this booklet. Additionally, your out-of-pocket prescription drug expenses are not applied to your medical option's annual out-of-pocket maximum.

Prescription drug expenses paid by the Plan are accumulated toward your Plan lifetime maximum.

### ***Under the Healthy Savings Medical Option***

If you're enrolled in the Healthy Savings PPO or Healthy Savings Out-of-Area medical option, your prescription drug benefits are paid as follows:

- **Preventive care medication** — You are not required to meet the deductible before benefits are paid at the coinsurance level
- **Not a preventive care medication** — Your benefits are applied to the medical plan annual deductible, annual out-of-pocket maximum, and lifetime maximum

### **Participating Retail Pharmacies**

Medco maintains an extensive network of participating pharmacies nationwide, including many major pharmacy chains and independent pharmacies. To find a participating pharmacy near you, find a link to Medco from [www.UPSers.com](http://www.UPSers.com), or call Member Services at 1-800-346-1327.

To receive your Plan benefit, present your Medco ID card to the pharmacist along with your doctor's prescription. You don't have to file any claim forms. Your retail

pharmacy benefit depends on your medical option and whether you obtain a brand or generic drug. See the *Summary of Benefits* section for details.

Your retail pharmacy benefits cover up to a 31-day supply of medication with each prescription. If you need more than a 31-day supply, you may be required to order your medication through the Medco By Mail program.

Prescription drugs considered maintenance (long-term) medications must be purchased through Medco By Mail home delivery service. If you purchase a maintenance drug at a retail pharmacy, the Plan pays the retail pharmacy benefit the first three times. After that, you are required to use Medco By Mail or you will be responsible for the entire cost of the drug.

### **Non-Participating Pharmacy**

You must pay the full amount of each prescription and then submit a completed claim form for reimbursement if you:

- Use a non-participating pharmacy,
- Fail to present your prescription drug card at a participating pharmacy, or
- Have transition coverage.

Your cost will equal the difference between the full retail cost and the discounted amount, plus your coinsurance. Go online at [www.medco.com](http://www.medco.com) or call Medco's Member Services at 1-800-346-1327 for a claim form. Claims must be received within 12 months of the date the prescription is filled. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement. See the *Filing a Claim* section for more information.

### **Preventive Care Medications**

*Preventive care medications are drugs designed to prevent a medical condition, not to treat an existing one. Examples of preventive drugs include those used to prevent high blood pressure or high cholesterol. To ensure that participants in the Healthy Savings option remain eligible for a Health Savings Account, a determination as to whether a drug is "preventive" will be determined, in part, according to applicable IRS guidelines.*

### About Generic Drugs

*It's a good idea to ask your physician to prescribe generic medications whenever possible. The generic name of a drug is its chemical name (for example, penicillin). The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs are required to meet the same standards for safety, purity, strength and effectiveness.*

## Prescription Drug Benefits (cont.)

### Medco By Mail

The Medco By Mail program gives you and your family a convenient, money-saving way to purchase maintenance medications, which are drugs prescribed for long-term or ongoing conditions such as high blood pressure, allergies or diabetes. You are required to purchase maintenance medications through Medco By Mail.

When you use the Medco By Mail program:

- You can order up to a 90-day supply of most medications
- You don't have to file a claim form or wait for reimbursement
- Ordering is easy. This is what you do:
  - Ask your physician to prescribe up to a 90-day supply, plus refills, of your medication.
  - Complete the patient questionnaire included with your Medco information kit. You can go to [www.medco.com](http://www.medco.com) or call Medco's Member Services at 1-800-346-1327 for a questionnaire.
  - Mail the questionnaire in the special mail service order envelope (included with the questionnaire), along with your original prescription. Or, you can ask your physician to fax the prescription to Medco at 1-800-837-0959 (You cannot fax the prescription yourself to Medco.)
- Your medication is delivered to your home by UPS within 14 days from the day Medco receives your prescription.
- Prescriptions are filled by registered pharmacists who compare your prescription to your personal medical profile to safeguard you against adverse reactions.

### Refill Prescriptions Online

You may also order Medco By Mail prescription refills over the Internet by visiting Medco's Web site anytime,

24 hours a day, seven days a week. Log on to [www.medco.com](http://www.medco.com).

### Prior Authorization Program

Medco retail pharmacies and Medco By Mail have a prior authorization program that evaluates the necessity of using certain drugs in certain situations. Your pharmacist will advise you if your prescription requires prior authorization. Then, you or your physician must call Medco at 1-800-346-1327 to request prior authorization for coverage of these drugs. The list of drugs requiring prior authorization may change from time to time. Contact Medco for more information.

### Specialty Drug Program

Certain specialty drugs must be obtained through Medco's specialty care pharmacy, Accredo Health Group. Specialty drugs are those high-cost medications that:

- May require specialized patient training and coordination of care prior to and during therapy
- May require unique patient compliance and safety monitoring
- Have unique requirements for handling, shipping and storage, and/or
- Have a potential for significant waste

You may qualify for the specialty drug program if your condition (such as rheumatoid arthritis, auto-immune diseases or multiple sclerosis) requires your doctor to prescribe certain drugs (such as IVIG, Procrit, Enbrel or Remicade) that meet the above criteria.

Prior to prescribing a specialty drug, your medical provider must contact Accredo Health Group at 1-800-501-7260.

Specialty medications not purchased from Accredo Health Group will **not** be covered under this plan.

## What is Covered by Your Prescription Drug Benefits

- Drugs approved by the FDA
- State-restricted drugs
- Insulin — by prescription only
- Insulin needles, syringes, test strips and over-the-counter diabetic supplies — by prescription only
- Compounded medications
- Smoking deterrents (with a lifetime limit of one 90-day supply)
- Oral contraceptives
- Drugs that are determined by Medco to be medically necessary

## What is Not Covered by Your Prescription Drug Benefits

- Any prescription refilled more than the number of times specified by the prescribing physician or any refill dispensed after one year from the physician's original order
- Over-the-counter medications, other than diabetic supplies
- Contraceptive devices
- Therapeutic devices or appliances
- Drugs used for cosmetic purposes
- Drugs for sexual dysfunction
- Dietary supplements, including any supplement for newborn infants
- Infertility drugs used or intended for the purpose of becoming pregnant, or assisting in inducing pregnancy or the process of becoming pregnant
- Drugs labeled "Caution: limited by federal law to investigational use," or experimental drugs, even when a charge is made to the individual
- Drugs not approved by the FDA
- Medication taken by or administered to a person, in whole or in part, while he or she is a patient in a licensed hospital,

nursing home or similar institution that has a facility for dispensing pharmaceuticals on its premises

- Growth hormones without prior authorization (see *Prior Authorization Program* in this section)
- Expenses listed as not covered in this section
- Medication for which the cost is recoverable by Workers' Compensation, occupational disease law, any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the participant

## Maintenance of Benefits and Coordination with Medicare

If you or your covered dependent(s) are also covered under Medicare, there are rules that determine whether the Plan pays benefits, or whether Medicare is primary. See *Coordination with Medicare* in the *Filing a Claim* section for more information.

The maintenance of benefits provision of The Flexible Benefits Plan does **not** apply to your prescription drug benefits.

## Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details on the Plan's right of recovery provisions.

## How to File a Claim

See the *Filing a Claim* section.

## Dental Benefits

The Flexible Benefits Plan offers you a choice of three dental options, all administered by Aetna®. The dental options cover the same services, but the benefit payable by the Plan differs from one option to another. You can also choose no dental coverage.

### Two-Year Rule

The dental plan has a two-year rule. For the dental plan, this means that:

- Once you choose a dental option, you must keep dental coverage at the same **coverage category** (meaning whom you choose to cover — you only, you plus spouse, you plus children, or you plus family) for two years. However, you may change your dental **option** (for example, from Dental Option 1 to Option 3) during the next annual enrollment period
- If you elect no coverage for dental, there will be a two-year waiting period before you can be covered by any dental option
- If you do not make any elections during your **initial** enrollment period (and therefore have no dental coverage), you may elect dental coverage at the first annual enrollment following your initial enrollment period

The two-year period begins:

- On your coverage effective date, or
- On January 1 following your first annual enrollment period if you failed to elect dental coverage during either your initial enrollment or your first annual enrollment

During any two-year period, you may be allowed to change your coverage **category** if you experience a qualifying life event. See the *Life Events* section of this booklet for more information.

For purposes of calculating the two-year period, a partial year counts as a full year for employees newly eligible for The

Flexible Benefits Plan and for employees making a mid-year change following a qualifying life event.

## Member Services

Member Services is your link to the dental PPO and DMO. You can reach Member Services by calling 1-877-263-0659 to:

- Ask questions about your benefits
- Obtain information about a network provider or service
- Seek help in filing claims, or
- Change your DMO personal dentist

You may also be connected to Aetna Dental by calling 1-800-UPS-1508 and following the prompts. Many services are also available online at [www.aetna.com](http://www.aetna.com).

## Guide to Dental Networks

Options 1 and 2 are dental Preferred Provider Organization (PPO) plans, offering a network of participating dentists who have agreed to provide services at negotiated rates. If you enroll in a dental PPO option, you and your family can enjoy the benefits of network-based care. You can also choose to use out-of-network providers but your out-of-pocket expenses may be higher. The choice is yours each time you seek care.

Option 3 is Aetna's Dental Maintenance Organization (DMO®), which is also a network of dental providers. DMO benefits are provided through an insurance contract with Aetna. If you enroll in the DMO, you will be provided a Certificate of Coverage. If there is any conflict between the certificate or this description and the insurance contract, the contract will apply.

Network areas are subject to change. Your enrollment information will indicate whether you live within the dental PPO and/or DMO network areas.



### ***If You Live Outside the Network Area***

If you live outside the dental PPO network area, you receive benefits at the same coinsurance level as in-network coverage, but you do not receive the negotiated rates, even if you happen to see a network provider.

If you find that network providers are convenient to you, you may “opt in” to the network and receive negotiated network rates. Call the Benefits Service Center at 1-800-UPS-1508 for more information about opting in to a dental PPO.

### ***If You Don't Use an Aetna Dental Provider***

If you select Dental Option 1 or 2 (dental PPO) and choose to use dental providers outside the network, your out-of-pocket expenses may be higher. In addition, you are responsible for paying any charges that exceed the R&C limits of the Plan.

If you are enrolled in Dental Option 3 (DMO), you receive no benefits under the Plan if you choose to seek care from a dental provider who does not participate in the DMO network.

### ***Coordinating with Medical Coverage***

In all cases, if you're hospitalized for dental care, the dentist's charges are covered by the dental component of The Flexible Benefits Plan. Other eligible charges are covered by the medical component of the Plan (see the *Medical Benefits* section of this booklet).

### ***Dental Options 1 and 2 — Aetna Dental PPO***

A central feature of Options 1 and 2 is access to the dental PPO, a national network of preferred dental care providers who have agreed to a schedule of negotiated, discount rates. This means your out-of-pocket costs will generally be less when

you see a participating dentist. If you need specialty care, the dental PPO includes a national listing of specialty dentists. You may also select a non-participating specialist, although your out-of-pocket expenses may be higher. To view a summary of dental benefits under Options 1 and 2 and the DMO, see the *Summary of Benefits* section.

Once you've enrolled in Option 1 or 2, to receive in-network benefits be sure to show your dental ID card when you visit the dentist's office.

If you choose a dentist who does not participate in the dental PPO network, reasonable and customary limits (R&C) will apply. See *Glossary of Benefit Terms* in the *Overview of the Plan* section of this booklet for more information.

### ***Dental Annual Deductible***

The dental annual deductible is separate from the annual deductible that applies to your medical, behavioral health and prescription drug benefits. The dental deductible is the amount you pay for covered basic and major restorative services before Options 1 and 2 pay benefits. The deductible does not apply to preventive services or orthodontia. You must meet a new deductible every calendar year.

The individual deductible applies separately to each covered family member. However, if two or more family members' expenses combine to reach the family deductible, then the deductible for each family member is considered to be met, even if no single member reached the individual deductible.

If you receive services from both in- and out-of-network providers, the in- and out-of-network annual deductibles cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual deductible also applies toward meeting your out-of-network annual deductible, and vice versa.

### ***Finding a Provider***

To find a dentist participating in your network, call Aetna Dental at 1-877-263-0659 or call 1-800-UPS-1508 and follow the prompts. You may also go online at [www.aetna.com](http://www.aetna.com).

## Preauthorization Recommended

*Dental implants should be preauthorized in advance by Aetna to ensure that benefits will be paid.*

## Dental Benefits (cont.)

### Annual Maximum Benefits

The dental annual maximum benefit works very differently compared to the annual maximum out-of-pocket that applies to your medical, behavioral health and prescription drug benefits.

The portion of your claims paid by the Plan each year (not what you pay) including for preventive services, under Option 1 or 2 of the dental plan is applied toward the individual dental annual maximum. See the *Summary of Benefits* section of this booklet for the annual maximum benefit for the each dental option.

If you are enrolled in Option 1 and receive services from both in- and out-of-network providers, the in- and out-of-network annual maximums cross-apply. This means that the amount of a claim that is applied toward meeting your in-network annual maximum also applies toward meeting your out-of-network annual maximum, and vice versa.

### Predetermination of Benefits

Options 1 and 2 have a provision that allows you to find out, in advance, what benefits would be paid for dental services you are considering. If you anticipate that charges for a course of dental treatment will be more than \$300, you or your dental provider should submit an itemization of the proposed treatment (including recent pretreatment x-rays) to Aetna before work is begun — unless it's an emergency. An Aetna dental consultant will review the proposed treatment, and Aetna will inform you and your dentist of the amount of covered charges.

While predetermination isn't required, this provision lets you know — before treatment begins — what benefits you're eligible to receive and gives you the opportunity to discuss possible treatment options with your dentist.

### Preauthorization of Benefits

It is recommended that you seek preauthorization from Aetna for dental implants to determine in advance what benefits, if any, will be paid. No preauthorization is required for any covered services under the dental plan; however, you may be requested to provide documents necessary for review of a claim.

### What is Covered Under Dental Options 1 and 2

The dental PPO options cover four types of necessary dental care:

- Preventive services
- Basic services
- Major restorative services
- Orthodontia for children

In addition, benefits are payable for:

- Temporomandibular joint (TMJ) therapy
- Accidental injury treatment

This section describes the types of services and supplies covered by Dental Options 1 and 2. The exact amount paid for services and supplies depends on the dental option you select, whether or not you go to a participating dentist and whether it is necessary dental care, as determined by Aetna. See the *Summary of Benefits* section to view the benefits payable for covered expenses, both in- and out-of-network.

### Preventive Services

Covered preventive services are:

- Oral exams (twice a year\*)
- Prophylaxis — any type (twice a year\*)
- Topical fluoride applications for children, until the end of the year in which the child turns 15 (twice a year)
- Scaling and root planing — (four separate quadrants every two years)

*\*If additional examinations and scaling are necessary each year, your dentist should submit a letter to Aetna explaining the request. Aetna will respond directly to your dentist. No more than four examinations will be covered per calendar year.*

- Gingivectomy (one per quadrant/site every three years)
- Osseous surgery (one per quadrant/site every three years)
- Occlusal guards (one every three years)
- Problem focused exams (two per year)
- X-rays:
  - Full-mouth or panoramic (once every three years)
  - Bitewing (one set per year)
  - Vertical bitewings (one set every three years)
- Sealants for children, until the end of the year in which the child turns 14:
  - One application per tooth per 36-month period
  - Permanent first and second molars only

### Basic Services

Covered basic services are:

- Visits and exams
  - Professional visit after hours
  - Special consultation by a specialist
  - Emergency palliative treatment
- X-ray and pathology
  - Single films (up to 13)
  - Intra-oral, occlusal view, maxillary or mandibular
  - Upper or lower jaw, extra-oral
  - Biopsy and examination of oral tissue
  - Study models
  - Microscopic examination
- Oral surgery — includes local anesthetics and routine postoperative care
  - Extractions
    - Uncomplicated
    - Surgical removal of erupted tooth
    - Postoperative visit (sutures and complications) after multiple extractions and impaction
  - Impacted teeth
    - Removal of tooth
  - Alveolar or gingival reconstructions
    - Alveolectomy (edentulous) per quadrant
    - Alveolectomy (in addition to removal of teeth) per quadrant
    - Alveoplasty with ridge extension, per arch
    - Removal of exostosis
    - Excision of hyperplastic tissue, per arch
    - Excision of pericoronal gingiva
  - Odontogenic cysts and neoplasms
    - Incision and drainage of abscess
    - Removal of odontogenic cyst or tumor
  - Other surgical procedures
    - Sialolithotomy — removal of salivary calculus
    - Closure of salivary fistula
    - Dilation of salivary duct
    - Transplantation of tooth or tooth bud
    - Removal of foreign body from bone (independent procedure)
    - Maxillary sinusotomy for removal of tooth fragment or foreign body
    - Closure of oral fistula of maxillary sinus
    - Sequestrectomy for osteomyelitis or bone abscess, superficial
    - Condylectomy of temporomandibular joint
    - Meniscectomy of temporomandibular joint
    - Radical resection of mandible with bone graft
    - Crown exposure to aid eruption
    - Removal of foreign body from soft tissue
    - Frenectomy
    - Suture of soft tissue injury
    - Injection of sclerosing agent into temporomandibular joint
    - Treatment of trigeminal neuralgia by injection into second and third divisions



## Dental Benefits (cont.)

- Anesthetics
  - General, only when provided in conjunction with an eligible surgical procedure
- Periodontics
  - Emergency treatment (periodontal abscess, acute periodontitis, etc.)
  - Subgingival curettage or root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants per year
  - Correction of occlusion related to periodontal surgery, per quadrant
  - Gingivectomy (including post-surgical visits) per quadrant
  - Gingivectomy, treatment per tooth (fewer than five teeth)
  - Osseous or muco-gingival surgery (including post-surgical visits)
  - Crown lengthening — reviewed on a per claim basis. Predeterminations are suggested.
- Endodontics
  - Pulp capping
  - Therapeutic pulpotomy (in addition to restoration)
  - Vital pulpotomy
    - Root canals (devitalized teeth only), including necessary X-rays and cultures but excluding final restoration
      - Canal therapy (traditional or Sargenti method)
      - Single rooted
      - Bi-rooted
      - Tri-rooted
      - Apicoectomy (separate procedure)
- Basic restorative — excludes inlays, crowns (other than stainless steel and bridges). Multiple restorations in one surface will be considered as a single restoration.
  - Restorations (involving one, two or three or more surfaces)
    - Amalgam filling
    - Silicate cement filling
    - Plastic filling
    - Composite filling — the alternate benefit of an amalgam filling will be given when placed on posterior teeth
  - Pins
    - Pin (retention) when part of the restoration used instead of gold or crown restoration
  - Crowns
    - Stainless steel (when tooth cannot be restored with a filling material)
    - Crown build-up — will be reviewed by a dental consultant for necessity
  - Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Partial denture repairs (metal)
    - Replacing missing or broken teeth except congenitally missing teeth
  - Adding teeth to partial denture to replace extracted natural teeth
    - Teeth and clasps
  - Recementation
    - Inlay
    - Crown
    - Bridge
  - Repairs — crowns and bridges
- Space maintainers — includes all adjustments within six months after installation
  - Fixed space maintainer (band type)
  - Removable acrylic with round wire rest only
  - Removable inhibiting appliance to correct thumbsucking
  - Fixed or cemented inhibiting appliance to correct thumbsucking

### Major Services

Covered major services are:

- Major restorative — gold restorations, inlays, onlays and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge or partial denture. Only restorations

needed for severe attrition, abrasion or erosion are covered.

- Inlays and onlays
  - One or more surfaces
- Crowns
  - Acrylic
  - Acrylic with gold
  - Acrylic with non-precious metal
  - Porcelain
  - Porcelain with gold
  - Porcelain with non-precious metal
  - Non-precious metal (full cast)
  - Gold (full cast)
  - Gold ( $\frac{3}{4}$  cast)
  - Gold dowel pin
- Prosthodontics
  - Bridge abutments (see inlays and crowns)
  - Pontics
    - Cast gold (sanitary)
    - Cast non-precious metal
    - Slotted facing
    - Slotted pontic
    - Porcelain fused to gold
    - Porcelain fused to non-precious metal
    - Plastic processed to gold
    - Plastic processed to non-precious metal
  - Removable bridge (unilateral)
    - One piece casting, chrome cobalt alloy clasp attachment (all types), including pontics
  - Dentures and partials (Fees for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
    - Complete upper denture
    - Complete lower denture
    - Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and two clasps
    - Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps
    - Additional clasps
    - Stress breakers
    - Stayplate, base — additional clasps
    - Office reline, cold cure, acrylic
    - Laboratory reline
    - Special tissue conditioning, per denture
    - Denture duplication (jump case), per denture
    - Adjustment to denture more than six months after installation
- Other services
  - Precision attachments (eligible with dentures if they are functionally necessary)
  - Implants (Pre-approval is recommended in advance. The teeth must be extracted or become missing while covered under the Plan)

### Alternate Benefit Provision

In some circumstances, an alternate service or supply may be suitable to treat or restore a dental condition, other than the service or supply recommended by your dentist. In this case, the Plan will pay only for the alternate service or supply. If you choose the recommended course of treatment, you will be responsible for the difference between the recommended course and the alternate benefit.

For example, your dentist may recommend a composite (white) filling for a posterior tooth. A suitable alternate treatment is an amalgam filling. The Plan will pay only for the amalgam filling. If you wish to have the composite filling, you will pay the difference between the composite and the amalgam filling.

While predetermination is not required, you may wish to submit your course of treatment in advance so you know what amount your dental option will pay. Some dental services or supplies (such as dental implants) may not have an alternate benefit provision. See *Predetermination of Benefits* in this section for more information.

*If you are new to The Flexible Benefits Plan's dental coverage and your child is involved in a course of orthodontic treatment when your coverage becomes effective, your Flexible Benefits Plan dental option will **not** pay benefits toward that treatment.*

## Dental Benefits (cont.)

### Orthodontia for Children

Dental Options 1 and 2 allow benefits for teeth straightening for your dependent children under 19 years of age. Services provided by December 31 of the year in which your child turns 19 are covered, as long as the treatment began before the child's 19th birthday.

Before treatment begins, the orthodontist should submit a total treatment plan to Aetna for approval, so that you and the orthodontist will know what treatment will be covered and the benefits payable.

Orthodontia benefits are not subject to the dental annual deductible. See the *Summary of Benefits* section for more information about orthodontia benefits. A lifetime maximum benefit applies to TMJ therapy combined with orthodontia for children.

Orthodontic benefit payments begin when an active appliance is installed in your child's mouth. The first orthodontic benefit payment is equal to 50 percent of the member's down payment, plus 50 percent of the fee for the diagnostic records. Thereafter, payments are made automatically each month, on or after the same day of the month in which the bands are placed. However, quarterly certification is required to verify that treatment is continuing.

Orthodontia expenses covered by Options 1 and 2 include:

- Initial consultation
- Moldings and impressions
- Installation of braces
- Regular visits

### Temporomandibular Joint (TMJ) Therapy

Treatment for temporomandibular joint dysfunction is covered for adults and dependent children. This coverage is only for TMJ appliance therapy (bite splints), adjustments and diagnostic materials (including impressions). See the *Summary of Benefits* section of this booklet to view the benefits payable under the dental option you choose.

Separate lifetime maximum benefits apply to:

- TMJ therapy for adults
- TMJ therapy combined with orthodontia for children

### Accidental Injury Treatment and Repair

Under Options 1 and 2, coverage for treatment and repair of sound teeth and gums damaged by an accidental injury will be covered as a regular dental expense, except that — for this treatment and repair of accidental injuries only — the deductible and the annual maximum will be waived for 36 months from the date of the injury. Under certain circumstances, this waiver may be extended for dependent children.

Additionally, orthodontic treatment required for repair will be covered for up to 36 months from the date of the injury, with the lifetime orthodontic maximum waived during this treatment period.

This benefit includes all eligible participants of the Plan, regardless of age. The treatment must be medically necessary to restore the teeth to their condition prior to the accident. Cosmetic treatment beyond restoration is not covered under this benefit.

All other dental care will continue to be subject to the annual deductible and annual maximum during these treatment periods.

### ***What is Not Covered Under Dental Options 1 and 2***

In addition to services not specifically listed in *Covered Expenses* above, the following expenses are not covered by the dental options:

- Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only
- Occlusal adjustment (unless following periodontal surgery) or retainers if charged separately from orthodontic treatment
- Claims received more than 12 months past the date of service
- IV sedation, except in certain circumstances; call Aetna at 1-800-UPS-1508
- Appliances, restoration or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting non-severe attrition or abrasion
- Dentures and bridgework when they are for the replacement of teeth that were extracted before the patient was covered by a UPS-administered dental plan
- Orthodontic treatment begun before covered by a UPS-administered dental plan
- Root canal therapy, if the pulp chamber was opened before the patient was covered by a UPS dental option
- Relines and adjustments of dentures and partial dentures within six months after installation
- Cosmetic dental services and supplies, including personalization or characterization of dentures
- Prosthetic devices and appliances, including bridges and crowns, and expenses for fitting or modifying them, if installed or delivered more than 30 days after the patient's coverage ends
- Replacement of lost, stolen or broken appliances
- Replacement of congenitally missing teeth
- Education programs, such as plaque control or oral hygiene instruction
- A charge for a replacement or modification of a partial or fully removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of an inlay, onlay, crown or cast processed restoration, within five years after installation
- Localized delivery of antimicrobial agents; such as Actisite®, Atridox®, Arestin® and PerioChip®
- Local anesthesia or nitrous oxide, as a separate charge
- Any prescription drug
- Full mouth debridement
- Guided tissue regeneration
- Desensitization treatment
- Precision attachments except as noted under *Major Services* in this section
- Infection control
- Behavior management
- Canal preparation, if submitted as a separate charge
- Rubber dam
- Services not required for the treatment of a specific condition or to maintain good dental hygiene, as determined by Aetna
- Services not reasonably necessary or customarily performed, as determined in keeping with guidelines adopted by Aetna
- Services not furnished by a licensed dentist, except services provided by a licensed hygienist under the direction of a dentist or X-rays ordered by a dentist
- Services covered by the medical options
- Charges for a missed or broken appointment
- Charges for the dentist's travel

*The DMO is available only in selected locations — you must determine whether a DMO dentist is available in your area prior to enrolling. Call Aetna Dental at 1-877-263-0659 or call 1-800-UPS-1508 and connect to Aetna's Member Services. You may also go online at [www.aetna.com](http://www.aetna.com).*

## Dental Benefits (cont.)

- Services which you would not be required to pay in the absence of dental coverage
- Treatment of a work-related injury
- Services furnished by or for the United States government or for any other government, including a service that may be covered under a government plan

### ***How to File a Claim Under Option 1 or 2 (Dental PPO)***

See the *Filing a Claim* section.

## **Dental Option 3 — Aetna Dental Maintenance Organization (DMO)**

When you select Dental Option 3, dental benefits are paid if services are provided by participating Aetna DMO dentists. There is no annual dental deductible. There are generally no claim forms to complete. In addition, you may have higher benefit levels and lower out-of-pocket expenses than through Option 1 or 2. **Please refer to your DMO Certificate of Coverage for specific benefit levels in your area.**

If you enroll in Option 3, you must choose a personal dentist from the DMO network. In order to receive the highest level of dental benefits, you must use the DMO personal dentist you've selected. Option 3 provides very limited benefits for services provided by a dentist who is not your DMO personal dentist.

Once enrolled, you and your dependents will receive DMO ID cards with your DMO personal dentist's name and phone number printed on the front.

### ***Selecting a DMO Personal Dentist***

You may choose a different DMO personal dentist for each member of your family. Aetna can assist you in selecting a DMO personal dentist who best meets your needs. You may change your DMO

personal dentist at any time by calling Aetna Dental at 1-877-263-0659. Aetna must submit the change to your new DMO personal dentist before you visit him or her. Before making an appointment with your new DMO personal dentist, call your new dentist to confirm that the change has become effective.

When you select a new DMO personal dentist, you will receive a new DMO ID card. Be sure to show your dental ID card when you visit your DMO personal dentist's office.

### ***Specialty Treatment***

If you need specialty care, your DMO personal dentist will refer you to a DMO dentist in your area who specializes in the services you need. If you don't obtain a referral, the specialist's services will not be covered by the DMO, even if the specialist is a DMO participant.

### ***Emergency Coverage***

If you have a dental emergency, call your DMO personal dentist. Your DMO personal dentist should respond to you within 24 hours to schedule needed treatment or refer you to the appropriate network specialist. If you cannot reach your DMO personal dentist, you must call 1-800-843-3661 to reach Aetna's DMO Member Services (or call 1-800-UPS-1508 and follow the prompts) to obtain a referral to another DMO dentist. If you do not seek DMO approval for emergency treatment, it will not be covered.

If you need emergency dental care while away from home, call your DMO personal dentist. If you are unable to reach your DMO personal dentist, call Aetna's DMO Member Services for treatment options and coverage levels. If you do not seek DMO approval for emergency treatment while away from home, it will **not** be covered.

### ***If Your Dentist Leaves the Network***

If your DMO personal dentist leaves the DMO network:

- You will receive written notification. If another DMO personal dentist(s) is in your area, you will be assigned to a new DMO personal dentist. However, you have the option of selecting another DMO personal dentist by contacting Aetna's DMO Member Services.
- If there are no other DMO dentists participating in your area, you may switch coverage to Option 1 or 2 by calling the Benefits Service Center at 1-800-UPS-1508. (See the *Life Events* section of this booklet.) If you choose to switch, you must select a new option within 60 days following the date of the notification.

### ***What is Covered Under Dental Option 3 (DMO)***

In general, the DMO covers preventive, basic, major and orthodontia services if the services are determined to be necessary by your DMO personal dentist and approved by Aetna. Specific coverage levels vary depending on where you live.

You will receive a Certificate of Coverage for the area in which you live after enrolling in the DMO. Your Certificate of Coverage contains detailed information on what is covered and what is not. You can also obtain the applicable Certificate of Coverage for your area by calling Aetna's DMO Member Services.

### ***How to File a Claim Under Option 3 (DMO)***

If you select Option 3 and receive services from a DMO provider, you generally do not have to file claim forms. You pay your portion of the bill at the time you receive the dental services.

### **Maintenance of Benefits and Coordination With Medicare**

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See *Maintenance of Benefits* and *Coordination with Medicare* in the *Filing a Claim* section for more information.

### **Right of Recovery Provision**

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details.

### **Coordinating with HMO Coverage**

*If you participate in a Kaiser HMO (in California or Hawaii only), additional coordination issues may exist for dental surgery. Call your HMO in advance of any dental surgery outside your dentist's office to ensure appropriate coverage.*



## Vision Benefits

The Flexible Benefits Plan provides benefits for an annual eye exam (Vision Exam Only) at no additional cost to you and your eligible dependents enrolled in medical coverage under the Plan. In addition, you have the option to select coverage for frames and lenses or contact lenses (Vision Lenses and Frames). Your vision benefits are administered by Vision Service Plan (VSP).

VSP has a network of doctor locations across the country that provide professional eye care, including eye examinations and the necessary corrective lenses. For routine vision care, you have the choice of using a VSP network provider or any provider you choose. However, you will receive higher benefits if you use a VSP provider.

All benefits are subject to vision plan limits. See the *Summary of Benefits* section in this booklet for the coverage level and plan limits for each vision benefit.

If you experience a medical problem with your eyes, you should consult your primary care physician. Non-routine vision coverage is provided through your medical claims administrator. See the *Medical Benefits* section for information about covered medical services.

### How Your Vision Benefits Work

To access in-network vision care benefits, contact your VSP participating doctor to make an appointment. If you need help locating a VSP participating doctor, contact VSP's Member Services at 1-800-877-7195 or online at [www.vsp.com](http://www.vsp.com).

When making an appointment, be sure to indicate that the patient is eligible for VSP benefits through UPS. You'll be asked to provide your VSP identification number (your Social Security number or Employee ID). The VSP provider will obtain the

necessary authorization and information about your eligibility and coverage under the vision plan.

### If You Don't Use a VSP Provider

If you choose to use a provider outside the VSP network, you can receive reimbursement for eligible care services up to the limits of the vision plan. To be reimbursed, you must submit an out-of-network claim form, available from [www.vsp.com](http://www.vsp.com) or by calling Member Services.

You can use a non-VSP provider for an eye examination, and then use a VSP provider for frames and lenses or contacts — if that VSP provider agrees to fill the prescription without an exam.

### Two-Year Rule

The vision plan has a two-year rule. This means that, if you select the Vision Lenses and Frames option, you must keep your Vision Lenses and Frames coverage at the same coverage category (meaning whom you choose to cover — you only, you plus spouse, you plus children or you plus family) — for two years. However, if you choose the Vision Exam option, you can change your selection during the next annual enrollment period.

### What is Covered by Your Vision Benefits

See the *Summary of Benefits* section of this booklet for your benefit, based on the vision option you choose and whether you use a VSP provider or non-VSP provider.

- Annual eye exam (Vision Exam Only)
- Annual eye exam plus your choice each year (Vision Exam, Lenses and Frames) of either:
  - Lenses and frames, or
  - Disposable contact lenses (if the entire benefit is used at one time)

### ***Available at an Additional Cost***

Vision benefits are designed to cover your corrective vision needs and not cosmetic materials. If you purchase any of the following, you are responsible for additional charges (at reduced prices if you use a VSP provider):

- Frames costing more than the vision plan limits
- Contact lenses costing more than the vision plan limits
- No-line, blended bifocal lenses
- Coated lenses

You are also eligible for the following discounts from your VSP provider, if purchased within 12 months of your eye examination:

- 20 percent discount on additional pairs of glasses
- 30 percent discount on additional pairs of glasses if purchased the same day as the initial pair
- 15 percent discount on contact lens professional services (fitting, evaluation and follow-up)

### ***Laser Vision Correction Surgery Discounts***

As a VSP member, laser vision correction surgery is available at discounted prices through VSP's Laser VisionCare<sup>SM</sup> network of doctors. Visit [www.vsp.com](http://www.vsp.com) to learn more about laser vision correction and participating doctors. Or, call VSP Member Services at 800-877-7195.

Lasik surgery is not covered by the vision component of The Flexible Benefits Plan.

### **What is Not Covered by Your Vision Benefits**

- Visual analysis that does not include a complete eye refraction
- Orthoptics or vision training
- Subnormal vision aids
- Aniseikonic lenses
- Duplicate or spare glasses
- Two pairs of glasses instead of bifocals
- Replacement of lost or broken lenses or frames (unless you have not already received a pair of lenses or frames that year)
- Eye exams, glasses or contacts provided by any other vision care plan
- Vision care services, materials or procedures covered by other provisions of the Plan. For example, vision therapy after cataract surgery is covered by the medical benefits
- Services or materials provided as a result of Workers' Compensation or similar legislation or provided through a government agency or program

### **Right of Recovery Provision**

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details.

### **How to File a Claim**

See the *Filing a Claim* section in this booklet.



## Solutions — Your EAP and Work/Life Benefit

To help you balance your responsibilities at work and in your personal life, Solutions offers free, confidential assistance with many of the work-life challenges you face each day. The Employee Assistance Program, administered by ValueOptions, provides practical solutions, information, advice and support for a wide range of work-life issues, including but not limited to anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns and parenting challenges.

### Eligibility

All regular active union-free employees, employees on an approved leave of absence, and their eligible dependents are covered under Solutions — Your EAP and Work/Life Benefit.

You do not have to enroll for this program; it is provided to you and your eligible dependents at no cost. EAP coverage begins when you become eligible for coverage under The Flexible Benefits Plan. Refer to the *Eligibility* section of this book for details regarding eligible dependents and when coverage begins.

### How the EAP Works

Solutions can help you handle problems that affect your physical and mental well-being, as well as your relationships. Solutions offers confidential access — 24 hours a day,

365 days a year — to trained professionals who will discuss your question, problem or concern. Depending on your situation, the Solutions counselor may refer you to a licensed network EAP provider in your community for up to six in-person visits, link you to available resources in your community, or offer you support over the telephone. Additionally, if the counselor determines the situation requires it, the participant may be referred for additional assistance to the group behavioral health plan. Any information about your call or treatment is confidential and may only be disclosed as permitted or required by law.

### Legal and Financial Assistance

Solutions also provides access to a national network of independent attorneys who have experience in a variety of legal areas, including bankruptcy, estate planning, taxes, family law, consumer and financial matters and traffic violations. For financial concerns, Solutions provides telephonic information and advisory services utilizing independent professionals with experience in financial matters, such as financial planners, certified public accountants and insurance specialists. If legal representation is needed, Solutions will provide a referral to a local network attorney, who has agreed to provide an initial one-half (½) hour, face-to-face consultation at no charge and has agreed to provide additional legal services at a 25 percent reduction of their customary fees. You are responsible for all

fees beyond the free initial consultation. The attorneys and financial professionals will assist you with most situations, but some restrictions do apply. These restrictions include but are not limited to:

- Employment issues — no advice will be offered on disputes between employee and employers
- Corporate law — questions pertaining to corporate law, including those generated from employee or spousal-owned businesses, will not be answered
- Second opinions — advice will not be given on how another attorney is handling a legal situation or rendering a subsequent opinion in case law
- Third-party callers — participants cannot seek advice to help with someone else's legal problems
- Investments — financial professionals will not provide advice regarding specific investment vehicles such as stocks, bonds or mutual funds. They can, however, provide advice on investment strategies

UPS provides no warranties or representations regarding the quality of services provided by each individual attorney or financial professional.

## **Additional Work/Life Services**

Work/life services include consultations with work/life specialists who research and provide referrals and educational materials that may include articles, checklists, booklets, and pamphlets, written by specialists and renowned experts and organizations. Work/life specialists can provide assistance with child and adult care providers, schools, colleges, adoption services, community resources and other daily living resources.

## **Contacting the Employee Assistance Program**

You can contact Solutions on their Web site at [www.achievesolutions.net/ups](http://www.achievesolutions.net/ups) or by phone at 1-800-336-9117. Please have the employee's name, phone number and birth date available when contacting Solutions — Your EAP and Work/Life Benefit.

## Quit For Life Tobacco Cessation Program

### Eligibility

Quit For Life® is available to all employees who otherwise satisfy the eligibility requirements for The Flexible Benefits Plan, including such employees on an approved leave of absence. Individuals who otherwise satisfy the requirements to be a “dependent” age 18 or older are also eligible for this program. See the *Eligibility* section for more information about eligibility for The Flexible Benefits Plan.

### Enrollment

You must enroll in the Quit For Life program in order to participate and receive the tobacco cessation benefits of the program. To enroll, access the Web site at the following URL: [www.freeclear.com/lups](http://www.freeclear.com/lups) or call 1-866-QUIT-4-LIFE.

### Program Benefits

Program benefits are provided at no additional cost to participants who enroll in Quit For Life, and include:

- Up to five outbound counseling and intervention calls to you
- In-depth assessment to evaluate readiness to quit tobacco use
- Assistance and support with over-the-counter Nicotine Replacement Therapy (NRT) in the form of patch or gum only. If you decide that NRT is right for you, this program provides an eight-week supply of NRT via direct mail order. There is no cost to you for the NRT
- This program provides assistance and support with NRT throughout the program cycle
- Assistance and support regarding prescription medications such as bupropion and Chantix\*

- A Quit Guide sent to your home following program registration
- Unlimited, easy, toll-free access to Quit Coaches® for twelve months from the time of enrollment
- Access to Web Coach, an interactive Web site that helps you stay on track between calls

*\*Prescription medication is not covered under this program. See the Prescription Drug Benefits section for information about prescription drug coverage under the Medical plan. Assistance and support provided by Free & Clear, the program's administrator, should not be a substitute for your doctor's advice.*

### Two Lifetime Quit Cycles

The Quit For Life program provides two lifetime quit attempt cycles per individual. For example: If, at the time of your fifth outbound intervention call you have not been successful in your attempt to quit, you will be offered an opportunity during the call to reenroll in the Quit For Life program. If you choose not to re-enroll at that time, you will be called again six months after your initial enrollment date and invited to re-enroll. This allows the Quit Coaches to build on your success and keep the positive momentum going; remembering that behavior change is a process, and each time you attempt to quit you are getting closer toward the ultimate goal of being tobacco free.

### When Benefits Begin

If you or your eligible dependents are already covered by the Medical plan, your benefits in Quit For Life begin the date you or your dependent enrolls in the program. If your Medical plan coverage has not begun, your benefits under the Quit For Life program begin the date coverage under the Medical plan begins or the date you enroll, whichever is later.

## Life Insurance and AD&D

Life insurance is primarily a benefit for your family or anyone who depends on you for support. Its purpose is to help provide your beneficiary with some measure of financial security in the event of your death. Accidental death and dismemberment (AD&D) insurance provides financial protection if you're seriously injured or die in an accident.

The Flexible Benefits Plan provides group term life insurance benefits through the following programs:

- Employee life insurance
- Spouse's life insurance
- Children's life insurance
- Employee accidental death and dismemberment insurance
- Family accidental death and dismemberment insurance

### Prudential Enrollment Kit and Contract-Certificate

Life insurance and AD&D benefits are provided through an insurance contract with Prudential Insurance Company of America. The benefits are described in this booklet for your convenience; however, for complete details you should also read:

- The Prudential Supplemental Term Life brochure, commonly known as the Prudential Enrollment Kit, provided with this Summary Plan Description, and
- The Prudential Insurance Group Contract-Certificate, available by contacting Prudential at 1-877-877-2955

If there is any conflict between the Prudential Insurance Group Contract-Certificate and this description or the Prudential Enrollment Kit, the Contract-Certificate provisions apply. The terms of the Prudential Enrollment Kit brochure are incorporated in and become part of this Summary Plan Description.

You may also contact Prudential for additional information by calling 1-877-877-2955.

### When Is Coverage Effective?

Coverage based on your initial enrollment elections begins at the same time your other elected Flexible Benefits Plan coverage begins. For annual enrollment elections, your coverage begins on January 1 of the following calendar year. All election changes related to status changes ("life events") are retroactive to the date of the event.

The following exceptions apply to the effective date of coverage:

- If you're ill or injured and absent from work on the date your coverage should start, coverage starts on the first day after you return to work for at least one full day (considered "active at work"). You are considered "absent from work" for these purposes even if you perform limited work from home while you are ill or injured. Your dependents' coverage is also delayed until your coverage starts.
- If you increase your coverage for any reason and are ill or injured and absent from work on the date the increased coverage should start, the incremental amount of the increased coverage will not be effective until after you return to work for at least one full day. If the increased coverage never becomes effective because you do not return to work, you will continue to be covered at the lower level of coverage that was in effect prior to the requested increase.
- If evidence of insurability is required, any amounts requiring approval will be delayed until the date approval is granted by Prudential. See *Evidence of Insurability (Good Health)* in this section.

*Basic and supplemental life and accidental death and dismemberment (AD&D) insurance are available to eligible covered same-sex domestic partners and/or their dependent children, in the same coverage amounts and at the same rates as other covered dependents.*

## Life Insurance and AD&D (cont.)

- If your dependent has had treatment for disease or injury within the 90-day period preceding the date coverage should start, coverage will not be effective until the dependent has been free from treatment for 90 days, or until evidence of good health has been approved by Prudential; whichever is earlier. This does not apply to newborns. However, stillborn deliveries are not covered.
- If your dependent is ill or injured and confined at home, in a hospital or other facility providing health care on the day coverage should start, his or her life insurance coverage begins 31 days after the end of the confinement, or with satisfactory evidence of the dependent's good health if earlier than 31 days.
- If you do not name a beneficiary, or if the beneficiary(ies) you name are not living at your death, 100 percent payment will be made to the following survivor(s) in the order shown below:
  - Your spouse
  - Your child(ren)
  - Your parent(s)
  - Your sibling(s)
  - Your estate

For example; if you didn't designate a beneficiary, your spouse would receive the full benefit, if he or she was living at your death. And, if your spouse was not living at your death, your child(ren) would receive the full benefit.

### Beneficiaries

To name a beneficiary for your life insurance and AD&D benefits, or to change your current beneficiary at any time, call 1-800-UPS-1508 to request a beneficiary designation form. Or, you can change your beneficiary designation online at Your Benefits Resources via a link from [www.UPSers.com](http://www.UPSers.com) on the My Life and Career tab. Your designation is not effective until the Benefits Service Center receives either your online beneficiary designation change or beneficiary designation form. The following beneficiary guidelines apply:

- You are automatically the beneficiary for your spouse's and children's life insurance and AD&D coverage.
- AD&D benefits other than for your death are payable directly to you.
- You may name anyone you choose as beneficiary for your life insurance benefits and AD&D benefits for your death. If you name more than one beneficiary, and do not indicate the percentage of your benefits you want paid to each individual, benefits will be divided equally between or among your beneficiaries.

### Basic Life Insurance

UPS pays the full cost of basic life insurance. The benefit amount of basic life insurance is:

- For you: 12 times your monthly salary
- For your spouse: \$2,000
- For your children: \$2,000

Your employee coverage amount is automatically updated with any changes to your monthly salary. Basic life insurance is group term life coverage. It can be converted to an individual policy if you leave or retire from UPS (see *If You Retire or Leave UPS* in this section). If you are unsure of your basic coverage amount, contact Prudential by calling 1-877-877-2955.

### Imputed Income

The value (as defined by the Internal Revenue Service) of your basic employee life insurance coverage over \$50,000 is taxable and is reported to the federal government on your W-2 form. This value is called "imputed income."

For example, if you had \$55,000 in basic employee life insurance, you would be taxed on the value of \$5,000 of insurance.

## Supplemental Life Insurance

If you want more insurance for yourself than your basic coverage, you can purchase supplemental term life insurance in \$1,000 increments up to a maximum of \$1 million. For details about this coverage, refer to the Prudential Enrollment Kit.

If you enroll in supplemental life insurance for yourself within 45 days of your initial eligibility date, you can receive up to the lesser of 48 times your monthly earnings or \$500,000 of coverage without having to provide evidence of insurability. Any coverage amount over \$500,000, or an amount elected more than 45 days after your initial eligibility date, will require evidence of insurability to be approved by Prudential.

### *Evidence of Insurability (EOI)*

For life insurance that requires evidence of insurability, Prudential will ask you to complete a form showing evidence of insurability (good health) before approving you for coverage. Your coverage will not be effective until the insurance is approved by Prudential and you meet the “active at work” requirements. In the meantime, coverage and payroll deductions will be set at the highest requested level available without evidence of insurability. Once approved, the coverage level and payroll deduction are increased retroactive to the date of approval.

### *Premium Rates*

Your annual premium rate, as shown in the Prudential Enrollment Kit, is based on your age and smoking status. The premium rate for your spouse is based upon his or her age and smoking status. This rate per \$1,000 of coverage is multiplied by the amount of coverage you elect.

## Dependent Supplemental Life Insurance

At your option, you may purchase dependent life insurance for your eligible spouse and/or eligible children. Refer to the Prudential Enrollment Kit for premium rates and complete details about coverage for your spouse and children.

If your spouse or child is eligible as an employee for supplemental life insurance through The Flexible Benefits Plan or another UPS-sponsored plan that offers supplemental life insurance, you may not cover your spouse or child for dependent life insurance through The Flexible Benefits Plan — your spouse or child should elect employee supplemental life insurance through his or her own employee plan.

### *Spouse's Life Insurance*

You may purchase supplemental term life insurance for your spouse in \$1,000 increments up to a maximum of \$500,000. This coverage includes all the same features as the employee supplemental term life coverage.

If your spouse enrolls within 45 days of his or her initial eligibility date, he or she can receive up to \$25,000 of coverage without providing evidence of insurability. Any amount over \$25,000, or any amount elected more than 45 days after the date your spouse becomes eligible for coverage, will require evidence of insurability to be approved by Prudential.

### *Children's Life Insurance*

You may purchase children's term life coverage in increments of \$1,000 up to a maximum of \$30,000. The cost per \$1,000 of coverage is the same regardless of how many children are covered.



## Life Insurance and AD&D (cont.)

### Monthly Salary

*If you are a salaried employee, monthly salary means your base pay, excluding bonuses, over-time or other incentive compensation. If you are paid weekly, monthly salary means:*

- *Full-time: Your hourly rate multiplied by 40 hours, multiplied by 52 weeks, divided by 12 months.*
- *Part-time: Your hourly rate multiplied by 20 hours, multiplied by 52 weeks, divided by 12 months.*
- *Part-time Supervisor or Specialist: Your hourly rate multiplied by 27.5 hours, multiplied by 52 weeks, divided by 12 months.*

### Accidental Death and Dismemberment (AD&D) Coverage

Accidental death and dismemberment coverage pays a benefit for certain injuries resulting from a covered accident. If the covered individual dies, the beneficiary receives the full amount. If the covered individual is injured, he or she receives all or a portion of the benefit, depending on the nature of the injury. More information about standard and additional benefits, additional family benefits, and benefit exclusions appears later in this section. A Schedule of Losses is included in your Prudential Enrollment Kit.

#### Basic AD&D Coverage

UPS pays the full cost of basic employee AD&D coverage, which is 12 times your monthly salary. Your coverage amount is automatically updated with any changes to your monthly salary. If you are unsure about your basic AD&D coverage amount, call 1-877-877-2955.

#### Supplemental AD&D Coverage

You may purchase supplemental AD&D coverage in \$1,000 increments up to a maximum of \$1,000,000. Evidence of insurability is not required for AD&D coverage. You may elect AD&D coverage for you only, or you plus family.

#### Family AD&D Coverage

Under family AD&D coverage, the benefit amount for your family is determined by the amount of family coverage you elect and your eligible dependents under The Flexible Benefits Plan, as shown in the table below.

<i><b>If Your Covered Family Includes You Plus...</b></i>	<i><b>Your Benefit Amount Is...</b></i>
Spouse only	70% of your coverage amount
Children only	50% of your coverage amount for each child (maximum \$50,000 per child)
Spouse and children	<ul style="list-style-type: none"> <li>• 60% of your coverage amount for your spouse</li> <li>• 25% of your coverage amount for each child (maximum \$50,000 per child)</li> </ul>

For example, if you elect \$100,000 of AD&D for you plus family and your spouse dies in a covered accident, you would receive:

- \$70,000 if your family consists of only you and your spouse
- \$60,000 if your family consists of you, your spouse and your children

In determining how to pay a benefit (spouse only, children only or spouse and children), Prudential relies on the UPS Benefits Service Center's record of your eligible dependents on file at the time of the covered accident. Each covered family member is an "insured."

### What is Covered by Your AD&D Benefits

#### Standard AD&D Benefits

Benefits are paid at certain percentages of your coverage amount for specific accidental losses. Not more than 100 percent of the coverage amount for the standard AD&D benefit is payable for all losses due to the same accident. The loss must be incurred within 90 days of the accident (paralysis within 365 days of the accident). Standard benefits apply to basic and supplemental coverage for you only and you plus family.

### **Additional AD&D Benefits**

If you are injured or die as a result of a covered accident, the Plan pays the following benefits in addition to the standard AD&D benefits. These additional benefits apply to basic and supplemental coverage for you only and you plus family.

- Seat Belt Benefit
- Air Bag Benefit
- Rehabilitation Benefit
- Continuation of Medical Funding Benefit
- Brain Damage Benefit
- Emergency Medical Evacuation/Return of Remains Service
- Home Modification Benefit

### **Additional Family AD&D Benefits**

If you elect supplemental family AD&D coverage and are injured or die as a result of a covered accident, the Plan pays the following benefits in addition to the amounts noted in the standard and the additional AD&D benefits.

- Spouse Tuition Reimbursement Benefit
- Child Tuition Reimbursement Benefit
- Day Care Expense Benefit
- Common Accident Benefit

### ***What is Not Covered by Your AD&D Benefits***

Basic and supplemental AD&D benefits do not cover a loss if it results from any of the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries while sane or insane
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment

- Any infection, unless pyogenic and occurring at the same time as the accident, cut or wound; or bacterial infection unless it results from accidental ingestion of a contaminated substance
- War or any act of war, declared or undeclared, including resistance to armed aggression
- An accident occurring while serving on full-time active duty for more than 30 days in any armed forces (does not include Reserves or National Guard active duty for training)
- Commission of, or attempt to commit, a felony
- Legal intoxication
- Use of narcotics (unless administered or consumed on a doctor's advice)

## **If You Retire or Lose Coverage**

### ***Portability of Supplemental Life Insurance***

If you retire or your supplemental life insurance coverage is terminated for any reason (except failure to make timely payments while on leave), the portability option lets you continue supplemental term life insurance. If you choose to continue your coverage under the portability option, your spouse may also continue his or her supplemental coverage under the portability provision. Your spouse may also elect to continue coverage individually if coverage under the Plan is lost due to divorce or death of the employee.

You will be billed directly by Prudential for your premiums. Since you are no longer a UPS employee, your group rates will no longer be the same as rates available to active UPSers, but will be based on a group made up of many Prudential customers. You can keep up to the current amount of your insurance without providing any evidence of insurability. Refer to the



## Life Insurance and AD&D (cont.)

Prudential Enrollment Kit for additional information regarding supplemental life portability.

Upon retirement or loss of coverage, you will receive portability information directly from Prudential. For more information regarding portability, call 1-877-877-2955 to speak to a Prudential Group Life Services representative.

If you choose the portability option and are later rehired or transferred to a UPS position that allows you to elect supplemental coverage under the Flexible Benefits Plan or another UPS-sponsored plan, you must surrender the ported coverage to receive supplemental coverage as an active employee.

### ***Conversion of Basic and/or Supplemental Life Insurance***

Another option if you retire or your life insurance coverage is terminated is to convert your basic and/or supplemental coverage to an individual life policy, without providing evidence of insurability. You should call the Prudential Group Conversion Office at 1-877-889-2070 to obtain a Conversion Kit. Your completed conversion application must be returned within 31 days of your last day of coverage in order to convert your coverage. Your spouse and/or dependent children may convert their coverage:

- When you are eligible to convert yours, as stated above
- If your spouse loses coverage due to a divorce, legal separation or your death, and/or
- If your child loses coverage because of your divorce, legal separation, your death, or having reached the limiting age

### ***When Basic and Supplemental AD&D Coverage Ends***

Your basic and supplemental AD&D coverage ends when you leave UPS or retire and your coverage otherwise ends under the Plan; it may not be ported or converted.

### ***Living Benefit Option***

The living benefit option provides you a portion of your life insurance benefit before your death if you are terminally ill with a life expectancy of less than 12 months. The coverage is a combination of your basic and supplemental benefit, up to a maximum of \$300,000. Additional information is in your Prudential Enrollment Kit. If you have any questions or would like a claim form, call Prudential at 1-877-877-2955.

### ***Permanent and Total Disability (PTD) for Part-Time Employees***

If you are a part-time employee not eligible for long-term disability (LTD) coverage and you become permanently and totally disabled while a participant in The Flexible Benefits Plan, you may be eligible to have your basic employee life insurance paid to you as a lump-sum benefit. In order to qualify for this benefit, you must be permanently and totally disabled from engaging in any occupation which could be considered reasonable — taking into account your age, education and prior work experience — as determined by Prudential. If you have questions or would like a claim form, call Prudential at 1-877-877-2955 and request the lump sum Total Disability Benefit option.

### ***How to File a Claim***

See the *Filing a Claim* section of this booklet.

## Tax-Advantaged Reimbursement Accounts

Tax-advantaged reimbursement accounts allow you to set aside pre-tax dollars from each paycheck to help pay for eligible out-of-pocket expenses.

There are three types of reimbursement accounts provided by The Flexible Benefits Plan:

- **Health Care Spending Account (HCSA)** for out-of-pocket medical, dental and vision expenses not reimbursed by the Plan. Individuals who enroll in the Healthy Savings medical option are **not** eligible for this option
- **Limited Purpose Spending Account (LPSA)** for out-of-pocket dental and vision expenses. Individuals who enroll in the Traditional medical option are **not** eligible for this option
- **Child/Elder Care Spending Account (C/ECSA)** for expenses related to the care of your qualifying dependents so that you — and your spouse, if you're

married — can work or attend school. This account is available regardless of the medical option you're enrolled in.

Health care expenses can include deductibles, coinsurance, and out-of-network or out-of-area charges that exceed reasonable and customary limits.

All of these accounts are strictly regulated by the IRS, which specifies the kinds of expenses that may be reimbursed or paid by each type of account. Refer to the table below for a general description of the reimbursement accounts available to you, based on your medical option. Additional information about each account appears later in this section. You are encouraged to also read the Internal Revenue Code sections 503, 502, 152, and 213(d) or consult your personal tax advisor for complete information about eligibility, use and limitations of the reimbursement accounts.

<i>Account</i>	<i>Description</i>	<i>Annual Contribution/ Reimbursement</i>	<i>Use With</i>
Health Care Spending Account (HCSA)	<ul style="list-style-type: none"> <li>• Used for out-of-pocket medical, dental and vision expenses</li> <li>• Eligible for streamlined claims submission and direct deposit for both Aetna and UnitedHealthcare members</li> <li>• Unused balance is forfeited after grace period</li> <li>• Administered by Aetna</li> </ul>	\$50 to \$3,500	Traditional medical option
Limited Purpose Spending Account (LPSA)	<ul style="list-style-type: none"> <li>• Used only for out-of-pocket dental and vision expenses</li> <li>• Unused balance is forfeited after grace period</li> <li>• Allows tax savings for Healthy Savings medical option participants</li> <li>• Administered by Aetna</li> </ul>	\$50 to \$3,500	Healthy Savings medical option (Participants in this medical option may also be eligible to contribute to a health savings account (HSA). See the <i>Medical Benefits</i> section for more details regarding HSAs)
Child/Elder Care Spending Account (C/ECSA)	<ul style="list-style-type: none"> <li>• Used for out-of-pocket child and elder care expenses</li> <li>• Eligible for direct deposit</li> <li>• Unused balance is forfeited at end of year</li> <li>• Administered by Aetna</li> </ul>	\$50 to \$5,000 (See Section 129 of the Internal Revenue Code)	Traditional or Healthy Savings medical option

## Tax-Advantaged Reimbursement Accounts (cont.)

### **Reimbursement Account Tax Advantages**

You don't pay federal or Social Security (FICA) taxes — and in most locations, state or local income taxes — on the portion of your pay that you contribute to a tax-advantaged reimbursement account. Certain states and localities include tax-advantaged reimbursement account deposits as taxable income. Consult your tax professional to find out whether such accounts are taxed in your area.

If you're a highly compensated employee (as defined by the IRS), the maximum amount you can contribute to the tax-advantaged reimbursement accounts may be limited. You'll be notified if these limits apply to you and your maximum contribution may be reduced.

### **How the Tax-Advantaged Reimbursement Accounts Work**

If you choose during annual enrollment to contribute to an HCSA or LPSA, and/or a C/ECSA, you begin by estimating the amount of eligible expenses you will incur in the coming year. Based on your estimate, you decide how much to contribute to each account. Then you enroll in each account independently of the other.

Your elections to contribute to one or more of these accounts are in effect during the entire calendar year. The amount you choose to contribute to your account is deducted, before taxes, from your regular pay in equal amounts throughout the year.

Once you have incurred eligible expenses:

- Your claims for reimbursement of medical and prescription drug expenses from your HCSA may be automatically processed if you choose (see *Streamlined Claims Submission and Direct Deposit* in this section). Or, you may submit a claim form for reimbursement if you prefer

- You must submit a claim form to be reimbursed for dental and vision expenses from your LPSA and/or child and elder care expenses from your C/ECSA

In all situations, you must provide documentation that substantiates the:

- Date the expense was incurred,
- Amount, and
- Nature of the expense.

For all types of tax-advantaged reimbursement accounts, you may choose to have your reimbursement (if approved) deposited automatically into your bank account (see *Streamlined Claims Submission* and *Direct Deposit* in this section).

Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

You may need to file a Form 2441 with your federal tax return and consult your tax professional with any questions.

### ***“Use It or Lose It” Rule***

It's important that you carefully estimate your expenses before you enroll in the HCSA, LPSA or C/ECSA because the Internal Revenue Service (IRS) requires that you forfeit any account balance not used to pay eligible expenses incurred during the year or — with the HCSA and LPSA — during the grace period. This is often called the “use it or lose it” rule. In addition, you cannot:

- Receive a refund of any unused balances
- Transfer your funds from one account to the other
- Carry funds over from one year to the next (except during the HCSA and LPSA grace period)
- Stop making contributions until the following January 1 unless an eligible life event occurs

Any forfeited amounts in the tax-advantaged reimbursement accounts are used by the Plan to offset administrative costs of the Plan or as otherwise permitted under applicable law.

## **Health Care Spending Account (HCSA) and Limited Purpose Spending Account (LPSA)**

The following information applies generally to both the HCSA and the LPSA.

- You can be reimbursed for health care expenses incurred by you and your eligible dependents if the expenses have not been reimbursed by any other arrangement (for example, from your spouse's flexible spending account), and you will not seek reimbursement for such expenses.
- Eligible expenses must be incurred during the year for which you make your HCSA or LPSA contributions, or during the grace period (see below). "Incurred" means the date the service is provided, not when you're billed or when you pay for it.
- You cannot take a deduction on your federal income tax return for any health care expenses for which you have been reimbursed through your HCSA.

### ***Eligible Dependents***

For the HCSA or LPSA, a "dependent" for whom you may claim eligible health care expenses is any individual who satisfies the requirements of Internal Revenue Code Section 105(b). This is your opposite sex spouse (as defined in accordance with state law) and any individual whom you can claim as a dependent under Internal Revenue Code Section 152 on your federal income tax return, or anyone for whom you could otherwise claim as a dependent on your federal income tax return except for the fact that he or she is married, has income in excess of the applicable exemption amount or is a dependent of a dependent.

In addition, a child to whom IRC Section 152(e) applies — which is generally a child of divorced or separated parents — is treated as a dependent of both parents for purposes of the HCSA, regardless of who actually claims the child as a dependent on his or her federal income tax return.

You may want to consult your tax advisor with any questions about tax dependency and qualification for eligible health care expense reimbursement for a same-sex domestic partner and/or their dependent children.

### ***Grace Period***

Any unused HCSA or LPSA funds may be used to reimburse eligible expenses incurred during the "grace period" that follows the end of the plan year in which you allocated HCSA or LPSA funds. The grace period begins on the first day of the next Plan year and ends two months and fifteen days later. For example, if the Plan year ends December 31, 2009, the grace period begins January 1, 2010 and ends March 15, 2010.

The following rules apply to the grace period:

- To take advantage of the grace period, you must be either a participant in the HCSA or LPSA on the last day of the Plan year to which the grace period relates, or a qualified beneficiary who is receiving COBRA coverage under the HCSA on the last day of the Plan year to which the grace period relates.
- Eligible expenses incurred during a grace period and approved for reimbursement are paid first from available amounts that were remaining at the end of the plan year to which the grace period relates, and then from any amounts that are available to reimburse expenses incurred during the current plan year.

## Tax-Advantaged Reimbursement Accounts (cont.)

- Claims are paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the plan year to which the grace period relates, if those expenses have not yet been submitted for reimbursement.
- Previous claims are not reprocessed or re-characterized so as to change the order in which they were received.

For example, suppose \$200 remains in your HCSA at the end of the 2009 Plan year and you elected to contribute \$2,400 to your HCSA for the 2010 plan year. If you submit for reimbursement an eligible medical expense of \$500 that was incurred on January 15, 2010, \$200 of your claim is paid out of the unused HCSA balance from the 2009 Plan year, and the remaining \$300 is paid out of your HCSA balance for 2010.

- You may not use HCSA or LPSA amounts to reimburse eligible child or elder care expenses.
- The grace period does not apply to any other reimbursement account.

### ***HCSA and LPSA Reimbursements***

Your reimbursements from the HCSA will equal the lesser of:

- The actual amount of your claim, or
- The total amount you've elected to contribute to the account for the year, less any reimbursement you've already received.

If you submit claims for less than \$50, Aetna will hold them until they total \$50 before making a payment (except at the end of the year, when you can submit smaller claims in order to clear the funds in your account). HCSA reimbursement checks are sent twice monthly.

Reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### ***Eligible Expenses\****

- Health plan deductibles, coinsurance and copayments, including those from other employers' plans; receipts for reimbursement of copayments or coinsurance — state the expense is a copayment or coinsurance
- Fees for doctors, dentists and hospital services not covered by a medical, dental or vision option, such as adult orthodontia
- Charges that exceed reasonable and customary amounts (see the Medical or Dental section of this booklet for an explanation of the term "reasonable and customary")
- Equipment and materials required for using contact lenses, such as saline solution and enzyme cleaners
- Over-the-counter medications, equipment and supplies when used for "medical care"\*\*\* and not for general well-being
- Reconstructive cosmetic surgery (surgery that is medically necessary to correct a deformity from a hereditary abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- Infertility treatment
- Capital expenses to install special equipment or make home improvements if the main purpose is medical care (such as installing entrance and exit ramps)

\*Based on applicable guidance relating to Internal Revenue Code Section 213(d).

\*\*You are responsible for providing all documentation deemed necessary by the claims administrator to support the fact that an expense is for "medical care."



### **Ineligible Expenses\***

- Health insurance premiums
- Athletic club expenses to keep physically fit, even if suggested by doctor
- Cosmetic surgery of a non-reconstructive nature
- Transportation costs of a disabled person to and from work
- Medical/dental expenses of a former spouse
- Qualified long-term care services
- Other expenses not considered “medical care”

*\*Based on applicable guidance relating to Internal Revenue Code Section 213(d).*

### **HCSA Only**

The following information applies only to the HCSA.

- You are eligible for the HCSA only if you enroll in the Traditional medical option. If you enroll in the Healthy Savings medical option, you are not eligible.
- Only expenses considered “medical care” as defined in Internal Revenue Code Section 213(d) (except for long-term care services and health insurance premiums) are reimbursable through your HCSA.
- Any receipts submitted to the HCSA for reimbursement of coinsurance or copayments must clearly state that the expense is a coinsurance or copayment; or it will be returned to you for additional information.

### **LPSA Only**

The following information applies only to the LPSA.

- You are eligible for the LPSA only if you enroll in the Healthy Savings medical option. If you enroll in the Traditional medical option, you are not eligible.
- Only dental or vision plan deductibles, copayments and coinsurance, including those from other employers’ plans, are

reimbursable. See a list of eligible expenses at [www.irs.gov](http://www.irs.gov) or [www.aetna.com](http://www.aetna.com).

### **Child/Elder Care Spending Account (C/ECSA)**

You can be reimbursed through a C/ECSA for eligible dependent care expenses that are incurred for the custodial care of an eligible dependent or for related household services, and to enable you (and your spouse, if applicable) to be gainfully employed or look for work.

Generally, you may contribute up to \$5,000 per year to your C/ECSA. The amount will be taken in equal amounts from each paycheck you receive during the year. If you choose to participate, your minimum contribution amount is \$50 annually. If you’re married and you and your spouse file separate tax returns, the maximum each of you can set aside for child/elder care reimbursement is \$2,500.

Whether an expense enables you (and your spouse, if applicable) to work or look for work should be determined on a daily basis. Normally, you should not include expenses incurred on days when you (and your spouse, if applicable) are not working or looking for work. However, you are not required to exclude expenses for a “temporary absence.” A temporary absence of two weeks or less is considered a temporary absence. If you’re a part-time employee who is required by the day care provider to pay for a full week or month, you don’t have to allocate days during that period that you didn’t work.

All eligible child care or elder care expenses must be incurred during the year for which you make your account contributions. An expense is considered incurred when the service is provided, not when you are billed or when you pay for it.

## Tax-Advantaged Reimbursement Accounts (cont.)

To receive reimbursements from the C/ECSA, you must provide written receipts showing the caregiver's name and taxpayer ID number or Social Security number. However, if the provider is a charitable organization — such as the YMCA, a church or similar organization — it is not necessary to provide the organization's taxpayer ID number.

### Eligible Dependents

You may receive reimbursements for eligible expenses incurred to care for your “qualifying dependents.” A qualifying dependent is any of the following:

- Your “qualifying child” (as defined by Internal Revenue Code Section 152) who is under age 13. Generally speaking, a “qualifying child” is a child (including a brother, sister, step sibling) of the employee, or a descendant of such child (for example, a niece, nephew or grandchild), who lives with you for more than half the year and does not provide over half of his or her support
- Your spouse or “dependent” who is physically or mentally unable to care for him- or herself. A “dependent” means any individual whom you can claim under Internal Revenue Code Section 152 as a dependent on your federal income tax return, or anyone for whom you could otherwise claim as a dependent on your federal income tax return except for the fact that he or she is married, has income in excess of the applicable exemption amount or is a dependent of a dependent. In addition, a child to whom Internal Revenue Code Section 152(e) applies, which is generally a child of divorced or separated parents, is considered a dependent only of the custodial parent, regardless of who actually claims the child as a dependent

### Eligible Expenses\*

- Amounts paid to a care provider (whether inside or outside your home), except as noted below
- FICA and other taxes you pay on behalf of the care/service provider
- Nursery schools, day camps and day care and elder care centers that meet state or local regulations, provide care for more than six non-residents and receive fees for services provided (per IRS rulings, pre-kindergarten is an eligible expense)

\*Based on Internal Revenue Service Publication 503, “Child and Dependent Care Expenses.”

### Ineligible Expenses\*\*

- Dependent care provided by a spouse, parent of the child, child under age 19, or by anyone you claim as a dependent on your federal income tax return
- Dependent care that isn't necessary to enable you (and your spouse, if applicable) to be gainfully employed
- Dependent care provided if your spouse does not work
- Any expense you plan to take as a credit on your income tax return
- Transportation to and from a dependent care location, except those charged by the day care provider to pick up and/or take the child to and from the day care center
- Care provided in a full-time residential institution
- Late payment fees
- Expenses for a provider's food, clothing and entertainment
- Expenses to care for dependents that do not live with you at least eight hours per day
- Expenses for overnight camp are not eligible day care expenses

\*\*Based on Internal Revenue Service Publication 503, “Child and Dependent Care Expenses.”



- Overnight care expenses (unless the parents work nights)
- Any portion of overnight camp, even if the daytime portion is broken out from the total camp fee on your receipt. To receive reimbursement for the daytime expense of any overnight camp, your receipt must include only the expenses for the daytime portion. Otherwise, your claim will be denied with no opportunity to resubmit it
- Expenses that are primarily for education, food and/or clothing are not considered to be for custodial care. Therefore, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, day camps are considered to be for custodial care even if they also provide educational activities such as soccer and computer skills
- Summer school and summer tutoring programs are considered to be “education” and therefore do not qualify as custodial care

### ***C/ECSA Reimbursements***

Reimbursements from the C/ECSA will equal the lesser of:

- The actual amount of your claim
- The amount of your account balance at the time the reimbursement is made

If you submit claims for less than \$50, Aetna will hold them until they total \$50 before making a payment (except at the end of the year, when you can submit smaller claims in order to clear the funds in your account). C/ECSA reimbursement checks are sent weekly.

Reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### ***Tax Credit vs. Child/Elder Care Spending Account***

For every dollar of reimbursement you receive through the C/ECSA, your dependent care tax credit is reduced by a dollar. So if you elect to participate in the C/ECSA, you are making a decision not to take the federal dependent care tax credit for those expenses.

In most cases, the C/ECSA will offer you the greater tax savings. However, it is important to note that in some cases, your tax savings may be greater if you use the dependent care tax credit rather than the C/ECSA for part or all of your dependent care expenses.

The following table compares the C/ECSA and the federal income tax credit. You may want to consult your personal tax advisor to see which method makes the most sense for you.

<b><i>Using the C/ECSA</i></b>	<b><i>Using the Federal Income Tax Credit</i></b>
Minimum annual contribution is \$50	No minimum annual expenses for using the tax credit
Maximum annual contribution is \$5,000 (\$2,500 each if married filing separately)	Maximum annual expense applicable toward tax credit is \$3,000 for one qualifying child; \$6,000 for two or more qualifying children
Contributions are excluded from taxable income	A percentage of expense is applied as credit against taxes owed
Contributions are free from Social Security taxes	Tax credit doesn't affect Social Security taxes
You must decide contribution amount before expenses are incurred and you forfeit the unused amount	You determine tax credit at the end of the year after all expenses are incurred; there's no risk of forfeiture

*Refer to IRS Publication 503 for a complete discussion of the tax credit. To order a copy, visit the IRS Web site at [www.irs.gov](http://www.irs.gov), or call 1-800-829-3676.*

## Tax-Advantaged Reimbursement Accounts (cont.)

### Streamlined Claims Submission and Direct Deposit

#### *Streamlined Claims Submission Processing Under HCSA*

Streamlined claims submission allows any unpaid amounts from medical expenses to be forwarded automatically to your HCSA by your medical or dental plan claims administrator once your medical or dental claim has been processed. In addition, any unpaid amounts from prescription drug expenses filed with Medco are forwarded automatically to Aetna (the UPS tax-advantaged reimbursement accounts vendor) for processing under your HCSA. Unpaid amounts are reviewed and reimbursed until you reach your annual contribution election. This eliminates the need to keep receipts or complete claim forms for reimbursement. Depending on the date of your claim, data transfer dates, and HCSA reimbursement schedules, the streamlined claims submission process can take up to 35 days.

#### *What Cannot be Streamlined*

The following types of claims cannot be streamlined and must be submitted with a claim form:

- Claims from claims administrators other than Aetna, UnitedHealthcare and Medco.
- Claims for reimbursement from your LPSA or C/ECSA.

#### *Direct Deposit of HCSA, LPSA and C/ECSA Reimbursements*

Direct deposit allows your tax-advantaged reimbursement account reimbursements to be directly deposited into your bank account, saving days in transit. Direct deposit applies to your HCSA, LPSA and C/ECSA reimbursements. HCSA and LPSA reimbursements are paid on days 15 and 30 of each month (or the first business day thereafter). C/ECSA reimbursements are paid weekly on Fridays. Reimbursements are usually available in your account within three to five business days.

#### *How to Enroll in Streamlined Claims Submission and Direct Deposit*

Enroll online at Your Benefits Resources through a link on [www.UPSers.com](http://www.UPSers.com). Or, call the Benefits Service Center at 1-800-UPS-1508 to request an enrollment form, which includes instructions for returning the completed form.

To participate in direct deposit, your bank must be part of the Automated Clearing House (ACH) System — call your bank to verify participation. Setting up Direct Deposit can take up to 35 days.

If you have an HCSA, by enrolling in either direct deposit or streamlined claims submission, you automatically are enrolled in both.

You do not need to sign up for this feature each year. Once enrolled, streamlined claim submission and direct deposit continue each year. To update your bank information in the future, find a link to Your Benefits Resources at [www.UPSers.com](http://www.UPSers.com), or call the Benefits Service Center at 1-800-UPS-1508 to request a new enrollment form.

## Impact on Other Benefits

While your tax-advantaged reimbursement account contributions reduce your taxable income, UPS-sponsored benefit amounts, like life insurance and disability, are based on your earnings before reimbursement account contributions have been withheld.

Be aware that, if you pay less Social Security (FICA) taxes because of your participation in tax-advantaged spending accounts, then your Social Security benefits at retirement, death or disability may also be lower. You will pay less FICA tax if your pay is at or below the wage base for Social Security taxes. However, whether your Social Security benefits will actually be lower depends on a number of factors, such as your current age, your earnings before participation in the accounts and future pay level.

## Run-Out Period

### *For the HCSA and LPSA Grace Period*

Expenses incurred during a grace period (HCSA or LPSA only) must be submitted before the end of the run-out period described below. This is the same run-out period for expenses incurred during the Plan Year to which the grace period relates. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan year to which the grace period relates or during the grace period will be forfeited if not submitted for reimbursement before the end of the run-out period.

If you take a leave of absence or have a status change, refer to the *Life Events* section for information about the impact to your spending accounts.

## For End-of-Year Claims

Claims for expenses incurred during the prior year must be received by the end of the run-out period, which is **May 31 following the end of the Plan Year**. After that date, any amount left in your account will be forfeited. This money will be used to offset future costs of administering the accounts, and then according to applicable rules and regulations.

## If You Retire or Leave UPS

When you terminate employment from UPS for any reason, claims for expenses that were incurred prior to your coverage termination date must be received within 90 days from the coverage termination date.

You may elect, through COBRA, to continue your HCSA or LPSA on an after-tax basis through the end of that calendar year (and through the grace period, if applicable). If you do so, claims for expenses that were incurred prior to the termination of your HCSA or LPSA COBRA coverage must be received by the earlier of:

- 90 days from the termination of your HCSA COBRA coverage, or
- The end of the standard claim filing period (May 31).

## How to File a Claim

See the *Filing a Claim* section.

Log on to Aetna's Web site at [www.aetna.com](http://www.aetna.com) any time to view your account information.

## Legal Plan

The Hyatt Legal Plan helps protect you from the financial expenses that may arise if you need legal services. This supplemental plan offers a range of commonly needed legal services as well as access to a legal hotline and individual consultation administered by Hyatt Legal Plans, a MetLife® company.

You and your covered family members will have access to the Hyatt Legal Plans network, a nationwide network of plan attorneys. You will receive full coverage for covered services from a Hyatt network attorney. You may also use any attorney of your choice; Hyatt will provide a fee reimbursement schedule that shows the maximum amount payable for specific services under the plan.

The legal benefits are provided according to an insurance contract issued to UPS by Hyatt Legal Plans. If there is any conflict between the summary of benefits provided in this booklet and the benefits described in the contract or on the Hyatt Legal Plans Web site, the description in the contract and/or on the Web site controls.

### Eligibility

The supplemental Hyatt Legal Plan is a voluntary benefit available to individuals and their dependents who are eligible for The Flexible Benefits Plan.

### Enrollment

You may enroll in the supplemental Hyatt Legal Plan benefit at initial enrollment, during annual enrollment periods, or following a recognized life status change.

### How the Legal Benefits Work

If you enroll for legal coverage, you have access to legal services from three sources:

- **Telephone Service** — You have access to advice, consultation and direction regarding personal legal matters that are not specifically excluded under the plan. There's no cost for this service
- **Hyatt Legal Plans attorneys** — If you need an attorney, you can choose one from Hyatt's national network of attorneys throughout the United States who have agreed to provide covered services to Hyatt Legal Plan participants. If you use a Hyatt Legal Plans network attorney, you will receive benefits for most covered matters
- **Non-Participating Attorneys** — You can also receive legal counsel from an attorney who does not participate in the Hyatt Legal Plans attorney network. When you use a non-participating attorney, you are reimbursed for covered legal services up to a scheduled maximum amount. You'll be responsible to pay the difference, if any, between the plan's payment and the non-network attorney's charge for services

As a participant in the Hyatt Legal Plan, there's no limit on how often you can use the plan. No matter how many times you utilize the plan, if you use a Hyatt network attorney, your payroll deduction stays the same.

### Legal Services Covered and Excluded

Listed below are examples of legal services that are provided according to the contract with Hyatt Legal Plans. If you're thinking about enrolling, visit their Web site at [www.legalplans.com](http://www.legalplans.com). Enter password 5530010 for the single plan or 5540010 for the family plan to access Hyatt Legal Plans' legal plan resource center. Or, call Hyatt Legal Plans at 1-800-821-6400.

#### Covered Legal Services

Examples of covered services include\*:

- Wills and estate planning
- Consumer protection matters, including small claims assistance
- Real estate matters, including sale or purchase of your home and property tax assessment
- Debt matters, including personal bankruptcy, tax audits, and identity theft defense

- Defense of civil lawsuits
- Document preparation, including deeds, mortgages and notes
- Family law, including premarital agreements, protection from domestic violence, and uncontested adoption
- Traffic matters/criminal, including juvenile court defense, restoration of driving privileges, and traffic ticket defense (does not include DUI)
- Immigration assistance

### ***Excluded Legal Services***

Examples of excluded services include services related to:

- Employment-related matters, including UPS or statutory benefits
- Matters involving the employer, MetLife and affiliates, and plan attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when the participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits

### **How to Use the Plan**

Once you are enrolled, log on to [www.legalplans.com](http://www.legalplans.com) or call Hyatt Legal Plans' Client Service center at 1-800-821-6400 Monday through Thursday from 8 a.m. to 7 p.m. (Eastern Time). A Client Service Representative will confirm that you are eligible to use the plan, and will give you the address and telephone number of the attorney(s) located most conveniently to you, as well as a case number. Once you have this information, you may contact the attorney yourself to schedule an appointment.

The Client Services Representative can also help you:

- Understand coverage
- Offer information about using an out-of-network attorney
- Answer any other questions

### **Cost of Coverage**

To determine how much the coverage will cost, call Hyatt Legal Plans at 1-800-821-6400.

### **Paying for Coverage**

Payment for legal plan coverage is made through after-tax payroll deductions.

### **Benefit Termination**

Generally, your coverage under this benefit ends when you retire or leave UPS for any other reason. However, you have the option to continue coverage through an individual policy. See *Portability* below.

### ***Portability***

You are eligible to convert your Hyatt Legal Plan coverage to an individual policy upon leaving UPS. If you choose to continue legal coverage, you will be billed directly for the cost. Contact Hyatt Legal Plans' Client Service center at 1-800-821-6400 for more information.

### **How to File a Claim**

If you choose to receive services from one from Hyatt's national network of attorneys, all covered services are paid in full — there is no need to submit a claim form.

If you use a non-network attorney, you will be reimbursed for covered services according to a set fee schedule. You are responsible to pay the difference, if any, between the plan's payment and the non-network attorney's charge for services. To request a claim form, contact Hyatt Legal Plans' Client Service center at 1-800-821-6400 or go online at [www.legalplans.com](http://www.legalplans.com).

## Adoption Assistance

To help UPS employees realize the dream of having a family, UPS offers eligible employees financial assistance through its Adoption Assistance Program. You are eligible for this benefit as part of the comprehensive basic coverage under The Flexible Benefits Plan.

### Eligibility

Employees are eligible for this benefit as part of the basic coverage under The Flexible Benefits Plan. You do not need to enroll separately in the Adoption Assistance Program benefit. There is no cost to you to take advantage of this program.

### Benefit Amount

UPS will reimburse 100 percent of eligible costs, up to \$3,500 per child, associated with the adoption of a child less than age 18 as long as the child is not related by marriage or blood. If both parents are UPS employees, expenses are reimbursed only one time per child, up to \$3,500.

### Children with Special Needs

If you adopt a child with a special need, the program will reimburse an additional \$1,500 in eligible expenses. A child with special needs often has a physical or emotional disability.

For the Adoption Assistance Program, documentation is required from the state in which the child is adopted certifying that the child qualifies for a special needs adoption in that state. Check with the applicable state social services division for information on that state's definition of special needs. International adoptions cannot be considered for the special needs benefit.

### What is Covered by Your Adoption Assistance Benefit

The Adoption Assistance Program covers the following adoption-related expenses:

- Legal/court fees
- Adoption agency fees (public or private, foreign or domestic)
- Medical expenses (when not covered by another source), including the following:
  - Newborn expenses
  - Maternity expenses for the birth mother
  - Charges for temporary foster care before placement
  - State-required home study program and other required adoptive parental counseling
  - Expenses to transport the child to the home

Call the UPS Benefits Service Center at 1-800-UPS-1508 to request a UPS Adoption Assistance Program claim form.



## What is Not Covered by Your Adoption Assistance Benefit

The following expenses are not covered by the UPS Adoption Assistance Program:

- Expenses incurred prior to the effective date of this plan or your eligibility for this plan
- Any costs when an adopting parent is related to (by blood or marriage) or a stepparent of the child being adopted
- Adoptions that are not legally recognized
- Personal items for the parents or child (food, clothing, etc.)
- Charges associated with legal guardianship
- Expenses related to the adoption of a person 18 years of age or older
- Donations or contributions
- Any costs when an adopting parent is the domestic partner of the parent of the child being adopted
- Consultant fee
- Any costs for or expenses of a surrogate mother (woman who is acting solely as a host of a fertilized egg)

## Adoption Assistance and Taxes

Adoption assistance expenses are not subject to federal income tax withholding but are subject to withholding of FICA taxes. Additionally, state or local income tax withholding may also be required if the state or municipality does not treat the reimbursement as nontaxable.

Certain amounts of your reimbursement may be subject to income tax if your income is over a certain level, as defined by the federal government. You may want to consult a tax advisor.

Taxable amounts are not grossed up to offset the tax liability.

Employees may be eligible for a tax credit for expenses not reimbursed by UPS.

Employees with unreimbursed adoption expenses should consult their tax advisor to determine the availability of tax credits.

## How to File a Claim

See the *Filing a Claim* section.



## Personal Lines of Insurance

Personal lines of insurance is a supplemental group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include:

- Auto
- Landlord's rental dwelling
- Condo
- Mobile home
- Renter's
- Recreational vehicle
- Boat
- Personal excess liability ("umbrella")

The program gives you access to special group rates and policy discounts\*. Additional program benefits include 24-hour claim reporting and coverage that you can take with you if you retire or leave UPS for any other reason.

You have a choice of insurance carriers for your personal lines of insurance. You may choose to purchase one or more policies from either of these carriers:

- Liberty Mutual®
- MetLife Auto & Home®

Although the personal lines of insurance are described in this booklet, they are not offered as part of The Flexible Benefits Plan.

*\*Group discounts, other discounts and credits may be available where state laws and regulations allow and may vary by state. To the extent permitted by law, applicants are individually underwritten and not all applicants may qualify.*

### Enrollment

You may enroll in the supplemental personal lines of insurance benefit at any time of the year by calling 1-800-UPS-1508 to connect to either MetLife Auto & Home or Liberty Mutual.

### Cost of Coverage

To obtain a quote for coverage, call 1-800-UPS-1508 to be connected to either Liberty Mutual or MetLife Auto & Home. Rates are subject to change.

Keep in mind that the rates quoted by MetLife Auto & Home or Liberty Mutual may not be the lowest in your area. You are encouraged to shop around and compare prices and services before making a selection.

### Paying for Coverage

Payment for auto and/or homeowners insurance can be made via direct billing or through payroll deductions. Both Liberty Mutual and MetLife Auto & Home offer an additional discount when payment is made via payroll deductions.

### How to Purchase Insurance

Call 1-800-UPS-1508 to be connected to Liberty Mutual or MetLife Auto & Home.

If you elect to purchase a policy, the paperwork is handled by the insurance carrier, including notification of the appropriate payroll deductions. All personal lines of insurance deductions are taken on an after-tax basis.

### Benefit Termination

Your coverage under the auto and/or homeowners insurance benefit continues until you notify the insurance carrier to discontinue coverage, or according to the specific terms of the insurance policy.

### Portability

If you retire or leave UPS for any other reason, the portability option lets you continue your auto and/or homeowners insurance through an individual policy; unless you notify your carrier to discontinue coverage. You will be billed directly for the cost of your coverage.

### How to File a Claim

To file a claim on your insurance policy, contact the insurance carrier directly at the number provided on your policy, or call 1-800-UPS-1508 to be connected to Liberty Mutual or MetLife Auto & Home.

## Critical Illness Insurance

Critical illness insurance (CII), which is insured by Metropolitan Life Insurance Company (MetLife), is designed to give employees the peace of mind needed to concentrate on recovery instead of finances. It provides a lump-sum benefit payment if you or your covered dependent experiences a first occurrence of the following medical conditions, as they are defined in the group insurance certificate:

- Cancer
- Heart attack
- Stroke
- Kidney failure
- Major organ transplant
- Coronary artery bypass graft

The CII benefit is available to active employees in The Flexible Benefits Plan and their eligible dependents.

CII benefits are provided through an insurance contract with MetLife. If there is any conflict between the MetLife group contract-certificate and this description, the contract-certificate provisions apply. You can obtain a copy of the contract-certificate by calling MetLife directly at 1-800-GET-MET8 or by connecting to MetLife at 1-800-UPS-1508.

### Eligibility

Employees who are actively at work (working at least 15 hours per week and regardless of age), along with their eligible dependents, may apply for coverage under the CII benefit. In order for an eligible spouse or child to have coverage:

- The employee must also have CII coverage, and
- The eligible spouse or child must have medical coverage (although coverage may be through any medical plan, not just one offered by UPS)

### Enrollment

You may enroll in the supplemental critical illness insurance benefit at initial enrollment or during annual enrollment periods.

### Examples of Benefit Uses

You can use the CII benefit for expenses associated with medical treatments or any other living expenses you might have — you may use the payment as you see fit. Examples of expenses include:

- Medical copays and deductibles
- Out-of-network treatments
- Prescription drug copays
- Child care bills
- Mortgage and rent payments
- Car payments
- Utility payments and other household bills

### Benefit Amounts

Coverage is available in the following amounts.

<b>Coverage For</b>	<b>Amount of Coverage</b>
Employee	Up to \$100,000 in increments of \$10,000
Spouse	Up to \$100,000 in increments of \$10,000*
Child(ren)	\$5,000

*\*A spouse's coverage cannot exceed the employee's maximum benefit amount.*

## Critical Illness Insurance (cont.)

### Cost of Coverage

To determine how much the coverage will cost, visit [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). Rates are subject to change and will increase when a covered person enters a new age band.

### Paying for Coverage

Payment for CII coverage is made through payroll deductions.

### Benefit Termination

Your coverage under this benefit continues until you notify MetLife in writing to discontinue coverage. See *Continuation of Coverage* below for more information.

### Continuation of Coverage

If you leave UPS upon retirement or for any other reason, the continuation of coverage option lets you continue your critical illness insurance. You will be billed directly for the cost of your coverage.

### How to File a Claim

For information about filing a claim or for any other questions, call 1-800-GET-MET8 (1-800-438-6388) to speak with a customer service representative, or you can register on their Web site at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

## Long-Term Care Insurance

Long-term care insurance, which is insured by Metropolitan Life Insurance Company (MetLife), protects you and your family from the high cost associated with long-term care. It's the type of care you need when you've had an accident or illness and are unable to care for yourself over an extended period of time. It provides assistance with daily activities like eating, bathing and dressing. Most health care plans, including those offered by UPS, are not designed to cover long-term care and do not cover custodial care at all.

Long-term care insurance benefits are provided through an insurance contract with MetLife. If there is any conflict between the MetLife group contract-certificate and this description, the contract-certificate provisions apply. You can obtain a copy of the contract-certificate by calling MetLife directly at 1-800-GET-MET8.

### Coverage Options

You have several options when electing long-term care insurance. First, decide how much coverage you want — \$100, \$200 or \$300 per day. Then decide how long you want your coverage to last — three years or five years.

### Non-Forfeiture Option

If you purchase this option and stop paying premiums, you keep a reduced level of benefit (a percentage of your total lifetime benefit). The amount will be based on the premiums you have paid after three years and will last at least 30 days.

### Eligibility

Individuals eligible for The Flexible Benefits Plan may elect long-term care insurance at any time. Coverage is available for:

- You
- Your spouse

- Your children and stepchildren over age 18
- Your parents
- Your parents-in-law
- Your grandparents
- Your grandparents-in-law

You are guaranteed coverage in the long-term care insurance plan if you enroll within 90 days of your date of hire, as long as you are actively at work (not absent due to illness, disability or leave) on the effective date of your coverage. Otherwise, you must provide a statement of health and be approved for coverage. Your eligible family members must provide a statement of health and be approved for coverage. There are no age limits.

### Enrollment

You may apply for the long-term care insurance plan at any time during the year. Call MetLife at 1-800-GET-MET8 Monday through Friday, 8:00 a.m. to 11:00 p.m. Eastern Time. You will be sent an enrollment packet and application.

If you enroll in long-term care insurance, you will be provided with a certificate of insurance. If there is any conflict between the certificate and this description, the certificate will apply. Plan features may vary by state.

### Cost of Coverage

To determine how much the coverage will cost, visit [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). Rates are subject to change.

### Paying for Coverage

Payment for long-term care insurance coverage is made through after-tax payroll deductions.

## Long-Term Care Insurance (cont.)

### Covered Services

You will be eligible to receive benefits when you provide proof satisfactory to MetLife, and you have been certified by a licensed health care practitioner, that you are chronically ill. Chronically ill means that you are unable to perform two of six “activities of daily living” (also known as ADLs) — eating, dressing, bathing, continence, transferring (for example, from bed to chair), or toileting; and are certified by a licensed health care practitioner to require assistance for at least 90 days. You will also be eligible if you require substantial supervision to protect yourself due to a severe cognitive impairment, such as Alzheimer’s disease.

Once you are approved for benefits, examples of benefits provided by the plan include:

- Planning services, including an initial care advisory visit
- Facility services, including nursing home care, assisted living or Alzheimer’s facility care, and hospice care
- Home/community care services, including home care, adult day care, and at-home hospice care

### What the Plan Does Not Cover

This Plan does not provide benefits for:

- Losses due to war or an act of war, participation in a felony, riot, or insurrection
- Service in the armed forces or auxiliary units
- Care or treatment outside the U.S. or its territories
- Treatment for alcoholism or drug addiction (chemical dependency) unless such drug addiction results from a doctor’s care
- Illness or injury that is intentionally self-inflicted
- Treatment in a government facility unless required by law

- Hospital care except for services in a distinct section licensed as a nursing home or hospice facility
- Expenses reimbursable by Medicare including deductible, coinsurance and copayment amounts except where Medicare is the secondary payor
- Charges for which you are not legally liable or which would not have been made if you were not a covered person
- Services by a member of your immediate family

These exclusions may not apply in all states and may vary depending on the state in which you live. The certificate of insurance you receive once you are insured will outline exactly the exclusions for your state. If you move to another state, the state guidelines where the certificate of insurance was originally delivered to you will apply.

### Benefit Termination

Your coverage under this benefit continues until you notify MetLife in writing or by phone at 1-800-GET-MET8 to discontinue coverage. See *Portability* below for more information.

### Portability

If you leave UPS upon retirement or for any other reason, the portability option lets you continue your long-term care insurance; unless you notify MetLife in writing or by phone at 1-800-GET-MET8 to discontinue coverage. You will be billed directly for the cost of your coverage.

### How to File a Claim

Contact MetLife at 1-800-GET-MET8 for information about filing a claim.

## Income Protection Plan

A total disability following an accident or illness is something that most people don't like to think about. However, should such a tragedy occur, the Income Protection Plan helps you bridge the financial gap caused as a result of lost income. All employees covered by The Flexible Benefits Plan are provided with coverage in the event of a disability.

There are two components to the income protection plan: short-term disability and long-term disability. Each of these is described in detail in this section.

### Short-Term Disability

Short-term disability (STD) protects your income if you have an absence caused by an illness or accidental injury, as determined by Aetna Disability and Absence Management (ADAM). An absence for maternity is treated like an absence for illness.

#### *Eligibility for STD Coverage*

Short-term disability coverage is available to active full-time and part-time employees who are eligible for coverage under The Flexible Benefits Plan.

#### *When You Become Covered for STD*

STD coverage is effective the date you become eligible for coverage under the Plan.

#### *When Your Coverage for STD Ends*

Your eligibility for STD coverage under the Plan automatically ends when one of the following occurs, whichever is earliest:

- Your employment with UPS terminates (see *Your Employment Status* in this section for additional information)
- Your eligibility for coverage under The Flexible Benefits Plan ends
- You retire, or
- You enter full-time military service

### STD Coverage

If you qualify for benefits, the STD plan pays a percentage of your base pay. For the exact percentage and details on how your benefit is calculated, refer to your SPD insert.

The maximum STD benefit is limited to 26 weeks in any rolling 18-month period for disabilities related to the same cause, as determined by the claims administrator. The number of weeks of STD you have available is determined by looking back 18 months from the date you start your leave and reducing the maximum 26-week period by the number of weeks of STD you have taken during that 18-month period for disabilities related to the same cause. A second disability related to an entirely different cause starts a new rolling 18-month period for that disability.

STD benefits are paid at the same interval that you are paid as an active employee; for example, benefits are paid weekly if you are a weekly-paid employee.

If you are an Administrative or Technical employee, your STD payment is based on your average, weekly base pay, which is calculated by averaging the paid hours (maximum of 40 per week) each week during the last quarter in which you worked the complete quarter, and multiplying that average by your hourly rate. A complete quarter is a quarter in which you have paid hours in each week of the quarter.

If you did not work the complete quarter, the Plan will look back a maximum of four quarters for the most recently worked complete quarter. If there is no complete quarter in the last four, the Plan uses the quarter with the most hours worked. The number of hours (maximum of 40 per week) and the number of weeks you worked in that quarter (not the total number of weeks in the quarter) are used to calculate your average weekly base pay.



## Income Protection Plan (cont.)

If you are a Management or Specialist employee, your STD benefit payment is based on your monthly base pay. Base pay is your regular weekly, semi-monthly or monthly pay, excluding any overtime, bonuses or incentives.

### ***Qualifications for Receiving STD Benefits***

For STD purposes, you are considered disabled if the claims administrator, ADAM, determines that you are unable to perform the material and substantial duties of your regular occupation because of an illness or injury. In some cases, STD benefits will be reduced if you refuse to participate in the residual disability return-to-work program.

Your date of disability (as determined by the claims administrator) must occur while you are covered under The Flexible Benefits Plan and prior to your termination date.

The fact that UPS has approved a leave of absence, made an accommodation (in keeping with Americans With Disabilities Act rules) or does not allow you to return to work in another position as a result of an injury or illness does not mean that you are “disabled” as defined by the Income Protection Plan.

Qualification for STD benefits is subject to you (or your physician at your request) providing objective clinical medical information to ADAM that supports your disability. You may also need medical approval prior to returning to work.

See *State-Mandated Benefits* in this section for more information regarding the interaction of Plan benefits and state-mandated disability benefits.

### ***STD Exclusions and Limitations***

No STD benefits are payable from this Plan for any disability that results from:

- Intentionally self-inflicted injuries
- Participation in a felony
- War, or act of war (whether such is declared or not), insurrection, rebellion, or participation in a riot or civil commotion
- Serving on active duty in any armed forces of any government
- Any vague or indefinable condition that cannot be described by a standard medical nomenclature diagnosis

No STD benefits are payable for days when you receive:

- Discretionary days (such as sick pay or optional holiday pay, if applicable)
- Holiday pay
- Vacation pay

### ***When STD Benefits Begin***

For Administrative and Technical employees, benefits begin on the first work day of an absence due to an injury and the fourth work day of an absence due to an illness. The period of time prior to when your benefits begin is considered your “waiting period.” Any unused discretionary days up to three will be used first before STD benefits are paid for an illness.

For Management or Specialist employees, benefits begin on the first work day of an absence due to an injury or an illness.

### ***Residual Disability/Return to Work Program While Receiving STD Benefits***

The Plan will pay a residual benefit if you return to work, at UPS or another employer, while recovering from a disability. You will be considered residually disabled if you



perform any work for wage or profit while disabled as defined by the Plan. The benefit you receive from STD will be calculated as follows: your STD benefit minus 75 percent of any earnings you receive while you are disabled.

Your residual earnings from all sources, combined with your STD payment, may not exceed 100 percent of your pre-disability base pay and any earnings (including earnings from other employers). Your STD payment will be reduced by any amounts in excess of your pre-disability earnings.

If ADAM and UPS determine that you can return to work for UPS under a residual disability program, and you fail to do so, your STD benefit payment will be offset by the amount you would have received as a residual disability benefit.

For purposes of this return-to-work program, you may be asked to return in any position for which you are reasonably qualified based on your education, training or experience.

If you return to work under a residual disability program, that time at work counts as part of your overall disability period. This means that your time at work under a residual disability program will not extend your disability period maximum.

### ***Health Care Coverage and STD***

For information about continuation of your health care coverage when you are on an approved disability, see *Health Care Coverage and the Income Protection Plan* in this section.

### ***State-Mandated Benefits***

California and Rhode Island have state-administered disability benefits. In these states, the UPS Plan offsets your STD

benefits by the amount of the state plan benefits so that the combined amount paid by the UPS Plan and the state plan would be no more than the amount the UPS Plan would pay if there were no other coverage. The claims administrator will automatically offset your UPS benefits unless you provide documentation that you are not receiving state disability benefits.

Hawaii, New Jersey and New York have state-mandated benefits. In these states, the amount paid to you will be the greater of either the state-mandated benefit or your STD benefit, but not both.

If you work in California, Hawaii, New Jersey, New York or Rhode Island and you do not satisfy the income protection plan's definition of disability (see *Qualifications for Receiving STD Benefits* in this section), you may still qualify for the applicable state's mandated benefit. Depending on the state, state-mandated benefits may be paid under the income protection plan or by a state-administered program. In addition, the fact that you are entitled to state-mandated benefits in California, Hawaii, New Jersey, New York or Rhode Island does not mean that you are "disabled" as defined by the income protection plan.

If the Plan determines that you do not satisfy its definition of disability, but you are deemed disabled under the applicable state standard in:

- **California or Rhode Island:** You will not receive benefits from the Plan.
- **Hawaii, New Jersey or New York:** You will receive only the state-mandated benefit from the Plan. In addition, there may be other remedies available to you through the applicable state's department of labor or other agency. You will be notified of your additional rights under state law in your claim denial letter.

## Income Protection Plan (cont.)

### **STD Benefit Offsets**

Your STD benefit will be reduced in full by other earnings (subject to the residual disability provisions) or disability income you may receive, or be eligible to receive, including:

- Any residual disability/return-to-work amounts that you may be eligible to earn
- Any Workers' Compensation payment
- Any amount you receive from another group insurance plan (individual insurance plans are not offset)
- Any no-fault or third-party benefit or settlement
- Any disability benefits received from the Veterans Administration
- Any primary benefits received under the Social Security Act
- Any incorrectly paid STD or LTD benefits
- State-mandated benefits as described in this booklet

It is a requirement of the Plan that you apply for the Social Security disability insurance benefit as well as any state-provided disability benefits to which you may be entitled. You are also required to appeal any denials. If you do not apply, or appeal denials, the claims administrator, ADAM, will estimate the Social Security amount and/or state-provided disability benefit that you could have received and offset your benefit by that amount.

Additionally, it is a requirement of the Plan that you apply for Workers' Compensation if your disability is work-related.

Should you receive a lump sum payment (for example, from Social Security, or a no-fault or third-party settlement related to your injury or illness), the portion of that total payment (less any attorney fees)

that represents disability benefits will be offset over the period for which the sum is given. If no period is given, the sum will be prorated as an offset over the 26-week STD period.

As an example, if you receive a \$100,000 settlement (that represents disability benefits) and your STD benefit is \$1,000 per month after all other offsets have been taken, you would receive no disability benefit from The Flexible Benefits Plan for 100 months, until the full \$100,000 had been offset. At that time, your disability benefit would begin again (to the extent you were still eligible). This example assumes qualification for LTD coverage after the STD benefit period ends.

If ADAM is unable to determine the exact amount of the award that represents disability benefits, 50 percent of the award will be considered disability benefits. This includes retroactive awards. Prorated offsets will begin when the lump sum payment is made.

In the event that you receive STD benefits for an illness or injury that is later determined to be an occupational illness or injury, you will be required to reimburse the Plan for any STD benefits you have received to date for that condition.

Additionally, if your remaining STD benefit period is not sufficient to repay amounts that would not have been paid to you (for example, if your Workers' Compensation claim had been determined earlier):

- Either your Workers' Compensation benefits will be reduced by the amount owed to the Income Protection Plan (to the extent allowed by law), or
- You will be required to reimburse the Plan for excess STD benefit payments

### ***Taxes and Your STD Benefit***

STD benefits are taxed when paid to you. See your SPD Insert for further details about receiving a W-2 form.

### ***When STD Benefits End***

You should contact your manager to keep him or her informed of your return-to-work status. If you qualify for long-term disability benefits, ADAM will automatically refer your case to MetLife for LTD coverage, or you may call MetLife at 1-877-638-4877 to discuss your qualifications for LTD benefits.

Certain conditions, as listed below, could cause your STD benefits to be terminated:

- You cease to have a “disability” that qualifies you for benefits under the Plan, as determined by the claims administrator
- Terminate employment due to a pre-disability scheduled termination date (for example, because of resignation, a facility closing, or a reduction in workforce)
- You fail to provide objective clinical medical documentation requested by the claims administrator. ADAM can request additional medical documentation of an ongoing disability as often as it deems reasonably necessary
- You fail to comply with a reasonable course of medical treatment and care necessary and appropriate to treat and/or resolve the condition for which you’re receiving disability benefits, including, but not limited to, receiving treatment from a health care or mental health professional who does not have appropriate training and experience in the field of medicine related to your particular disability

- You fail to comply with an independent medical examination, functional capacity evaluation or other evaluation as may be required by the claims administrator
- You begin receiving benefits from the UPS Retirement Plan
- You have been paid the maximum disability period of 26 weeks for STD benefits

If you can’t return to work when your benefits end, and you are a part-time employee not eligible to apply for LTD, you may be eligible for Permanent and Total Disability coverage. See *Permanent and Total Disability (PTD) for Part-Time Employees* in the *Life Insurance and AD&D* section of this booklet.

### **Long-Term Disability**

Long-term disability (LTD) coverage provides protection from disabilities caused by an occupational or non-occupational illness or injury that last longer than the 26-week STD benefit period, as determined by Metropolitan Life Insurance Company (MetLife), the LTD claims administrator.

- MetLife is the insurer for all long-term disability claims that have been approved as of December 21, 2009.
- For all other long-term disability claims that are not covered in accordance with the insurance contract mentioned below, UPS continues to temporarily fund the long-term disability claims (“self funded claims”) and MetLife is the claims administrator and the claims fiduciary. (See the *If a Claim is Denied* section of this booklet for more information about claims fiduciaries.) You will receive notice when MetLife takes financial responsibility for these claims.

### **Important Note About LTD Coverage**

*You’re responsible for any LTD costs based on your option. If you fail to enroll for LTD coverage, you will be assigned Option 3 and will be responsible for any costs associated with the coverage.*

## Income Protection Plan (cont.)

- MetLife insures long-term disability benefits for all qualifying disabilities arising on or after January 1, 2010, in accordance with an insurance policy issued by MetLife to UPS. If there is a conflict between that policy (and the associated insurance documentation) and this summary, that policy (and any the associated insurance documentation) controls. You can request a copy of that policy by contacting MetLife at 1-877-638-4877.

### ***Eligibility for LTD Coverage***

LTD coverage is a benefit generally available only to full-time employees who are eligible for medical coverage under The Flexible Benefits Plan.

### ***Permanent and Total Disability (PTD) for Part-Time Employees***

If you are a part-time employee and not eligible for LTD coverage and you become permanently and totally disabled while a participant in The Flexible Benefits Plan, you may be eligible to receive a lump sum benefit from your basic employee life insurance. See the *Life Insurance and AD&D* section for more information.

### ***When You Become Covered for LTD***

LTD coverage is generally effective on the date your other Plan coverage is effective. However, it could be delayed under certain circumstances.

If you increase your coverage for any reason and are ill or injured and absent from work on the date the increased coverage would otherwise start, the newly elected coverage will not be effective until after you return to work for at least one full day. You are considered “absent from work” for these purposes even if you perform limited work from home while you are ill or injured. If the increased coverage

never becomes effective because you do not return to work, you will continue to be covered at the option level that was in effect prior to the requested increase.

### ***When Your Coverage for LTD Ends***

Eligibility for LTD coverage under the Plan will automatically end for any disability that occurs after the earliest of these events:

- Your employment with UPS is terminated (see *Your Employment Status* in this section for additional information)
- You retire
- You cease to be an eligible employee
- You enter full-time military service
- You die, or
- You cease making contributions for the benefit

If your participation in LTD coverage ends, you may enroll only during the annual enrollment period, assuming you meet all eligibility requirements under The Flexible Benefits Plan.

### ***LTD Coverage Options***

If you qualify for benefits, the LTD plan pays a percentage of your monthly base pay, depending on the coverage option you elect during an enrollment period. Depending on the option you choose, you may be responsible for a portion of the cost of LTD coverage. Your cost share, if any, will be deducted from each paycheck you receive.

For hourly paid employees, your monthly base pay is calculated by multiplying your average weekly straight-time pay by 52 weeks, then dividing by 12 months, excluding any overtime, bonuses or incentives.

If you are a salary paid employee, base pay is your regular weekly, semi-monthly or monthly pay, excluding any overtime, bonuses or incentives.

Your base pay as of July 31 of the previous year (or as of your hire date, if later) is used to calculate your share, if any, of the cost of LTD coverage. Your cost share and coverage level will not change during the calendar year, even if your base pay changes. You have three LTD options from which to choose.

- Option 1 — 50 percent of monthly base pay
- Option 2 — 60 percent of monthly base pay
- Option 3 — 60 percent of monthly base pay to a maximum of 5 years

It's important to note that with Option 3, benefit payments cease at the end of five years, even if you are still disabled.

If you are a newly eligible employee who does not make an election, you will be assigned Option 3, which provides 60 percent of monthly base pay to a maximum of five years. You're responsible for any LTD costs.

You may use vacation pay accrued prior to your disability to bring your benefit up to 100 percent.

### ***No LTD Coverage Option***

If you meet certain age and years of service requirements, you will have a No Coverage option. Before electing the No Coverage option, you must verify that you are (or will be as of January 1 in the case of annual enrollment) at least age 55 with 10 years of UPS Retirement Plan vesting service or age 65 with five years of UPS Retirement Plan vesting service. It is your responsibility to ensure that you have the adequate years

of vesting service for your age, even if you are offered a No Coverage option. You can determine your years of vesting service at *Planning Your Financial Future*. Find the link at [www.UPSers.com](http://www.UPSers.com).

### ***Two-Year Rule for LTD Coverage Election***

There is a two year lock-in period for the LTD election you make. This means that you must keep your election for two years before you can change your election. For newly eligible employees, a partial year counts as a full year.

### ***Qualifications for Receiving LTD Benefits***

LTD benefits, if approved by MetLife, are payable to eligible full-time employees who are determined by the claims administrator to be disabled and who have exhausted their STD benefits. You are considered to have "exhausted" your STD benefits when you are no longer eligible to receive STD benefits because you have received the maximum STD benefit allowed under the Plan. If your STD benefits are denied for any reason prior to receiving the maximum benefit, you have not "exhausted" your STD benefits and you are not eligible for LTD benefits.

For the first 24 months of disability under LTD, you are considered disabled if MetLife determines that you are unable to perform the material and substantial duties of your regular occupation due to an illness or accidental injury.

After 24 months of payments, you will be considered disabled if MetLife determines that you are unable to perform the material duties of any gainful occupation for which you are reasonably qualified based on your education, training or experience; except for psychiatric benefits, which end at 24 months.



## Income Protection Plan (cont.)

Gainful occupation means any occupation for which you are reasonably qualified based on education, training or expertise at which you could earn at least 60 percent of your pre-disability base pay.

### ***LTD Exclusions and Limitations***

No LTD benefits are payable from this Plan for any disability that results from:

- Intentionally self-inflicted injuries, while sane or insane
- Participation in a felony
- War, or act of war (whether such is declared or not), insurrection, rebellion, or participation in a riot or civil commotion
- Any vague or indefinable condition that cannot be described by a standard medical nomenclature diagnosis
- Any disability that begins prior to LTD coverage under the Plan
- Psychiatric or nervous conditions, substance abuse and/or alcoholism (non-physical), except during the first 24 months of LTD. After 24 months, if you are confined in an accredited hospital due to a non-physical condition on the day that benefits would otherwise end, LTD coverage will only be continued if and for as long as you remain confined in such hospital for the treatment of a psychiatric/nervous condition.

Additionally, the Internal Revenue Code limits the compensation that can be used in computing long-term disability benefits. The calculation of long-term disability benefits under the Income Protection Plan will be limited to annual base compensation levels not exceeding \$245,000, as indexed for inflation. If your annual base compensation exceeds \$245,000 per year, you may be eligible for additional LTD benefits under the UPS Coordinating Benefit Plan.

### ***When Your LTD Benefits Begin***

In general, once approved by MetLife, your LTD benefits begin when your STD benefits have been exhausted.

### ***Residual Disability/Return to Work Program While Receiving LTD Benefits***

During the first 24 months of LTD, the Plan will pay a residual benefit if you return to work, at UPS or another employer, while recovering from a disability. You will be considered residually disabled if you perform any work for wage or profit while disabled. The benefit you receive from LTD will be calculated as follows:

- Your LTD benefit minus
- 75 percent of any earnings you receive while you are disabled

Your residual earnings from all sources, combined with your LTD payment, may not exceed 100 percent of your pre-disability earnings (including earnings from other employers). Your LTD payment will be reduced by any amounts in excess of your pre-disability earnings.

During the first 24 months of disability under LTD, if MetLife and UPS determine that you can return to work for UPS under a residual disability program, and you fail to do so, your LTD benefit payment will be offset by the amount you would have received as a residual disability benefit. For purposes of this return-to-work program, you may be asked to return in any position for which you are reasonably qualified based on your education, training or experience. If you return to work under a residual disability program, that time at work counts as part of your overall disability period. This means that your time at work under a residual disability program will not extend your disability period maximum.

### ***LTD Benefit Offsets***

Your LTD benefit will be reduced in full by other disability income or earnings you may receive, or be eligible to receive, including:

- Any amount received from a compulsory state disability plan
- Any Workers' Compensation payment
- Any residual disability/return-to-work amounts that you may be eligible to earn
- Any amount you receive from another group insurance plan (individual insurance plans are not offset)
- Any no-fault or third-party benefit or settlement
- Any disability benefits received from the Veterans Administration
- Any primary benefits received under the Social Security Act
- Any incorrectly paid STD or LTD benefits

It is a requirement of the Plan that you apply for the Social Security disability insurance benefit as well as any state-provided disability benefits to which you may be entitled. You are also required to appeal any denials. If you do not apply, or appeal denials, the claims administrator, MetLife, will estimate the Social Security amount and/or state-provided disability benefit that you could have received and offset your benefit by that amount.

Should you receive a lump sum payment (for example, from a no-fault or third-party settlement or Social Security), your LTD benefit from the Plan will be reduced in full until the amount of the lump sum payment that represents disability benefits has been completely offset. If MetLife is unable to determine the exact amount of the award that represents disability benefits, 50 percent of the award will be considered disability benefits. This includes retroactive awards. Prorated offsets will begin when the lump sum payment is made.

### ***Taxes and Your LTD Benefit***

LTD benefits are taxed when paid to you. The claims administrator, MetLife, will create all W-2 forms for any benefits received under the LTD Plan.

### ***Health Care Coverage and LTD***

For more information about continuation of your health care coverage while on an approved disability, see *Health Care Coverage and the Income Protection Plan* in this section.

### ***When Your LTD Benefits End***

LTD benefits will be terminated when an eligible employee reaches age 65, if the date of disability is prior to age 62. If disabled on or after age 62, LTD benefits terminate in accordance with the following schedule:

<b><i>If you were disabled at:</i></b>	<b><i>Your benefits continue:</i></b>
Age 61 or younger	To end of the month you reach age 65
Age 62	For 42 months
Age 63	For 36 months
Age 64	For 30 months
Age 65	For 24 months
Age 66	For 21 months
Age 67	For 18 months
Age 68	For 15 months
Age 69 or older	For 12 months

In addition to the above schedule, there are certain conditions, as listed below, that could cause your LTD benefits to be terminated:

- You cease to have a disability as defined by the Plan and as determined by MetLife
- You terminate employment due to a pre-disability scheduled termination date (for example, because of resignation, a facility closing or a reduction in workforce)



## Income Protection Plan (cont.)

- You fail to provide objective medical documentation requested by MetLife
- You fail to comply with a reasonable course of medical treatment and care necessary and appropriate to treat and/or resolve the condition for which you're receiving disability benefits which includes, but is not limited to, your receiving treatment from a health care or mental health professional who does not have appropriate training and experience in the field of medicine related to your particular disability
- You fail to comply with an independent medical examination, functional capacity evaluation or other evaluation as may be required by MetLife
- You fail to apply, reapply and appeal any denials of Social Security disability insurance benefits as well as any state-provided disability benefits to which you may be entitled, until all such applications and appeals are exhausted
- You begin receiving benefits from the UPS Retirement Plan
- You fail to comply with a residual disability/return to work plan approved by MetLife and UPS
- You elected LTD Option 3 and have reached the end of the five-year benefit period (even if you are still disabled)

### ***Health Care Coverage and the Income Protection Plan***

You and your covered dependents will continue to receive Flexible Benefits Plan coverage for up to 12 months following the date of your disability, as long as you continue to be approved for benefits by the claims administrator. You continue to be responsible for your share, if any, of the cost of coverage either through billing statements or payroll deductions (if you

are receiving a paycheck from UPS). At the latest, coverage will end on the last day of the twelfth (12th) full month of continuous disability, as long as you continue to pay your share of the cost.

You cannot change your elections for life or AD&D insurance while you are absent due to disability.

When your 12-month extension of health care coverage ends, you and your dependents may elect COBRA continuation for 18 months, for a total of 30 months of continued coverage. (See the *Continuation of Coverage Under COBRA* section for more information.) Or, if you are eligible and approved for LTD benefits, you may begin health care and basic life insurance coverage for you and your dependents and basic AD&D coverage for you under the Retired Employees' Health Care Plan. You will receive a Summary Plan Description for your LTD health care, life insurance and AD&D coverage when you are approved for LTD.

UPS pays for coverage in the Retired Employees' Health Care Plan for the first 18 months in the Plan. Thereafter you are required to pay the cost of coverage. Any credits you have accrued through the UPS Retirement Plan at the time of your disability are used to offset your cost. Credits accrue only while you are an active employee. See your UPS Retirement Plan SPD for information about credits.

If you become eligible for Medicare benefits as a result of a disability, there are rules that determine whether The Flexible Benefits Plan pays benefits first, or whether Medicare is primary. See *Coordination With Medicare* in the *Filing a Claim* section.

The Flexible Benefits Plan does not cover any expenses related to an occupational disability. You must submit claims directly related to your occupational disabilities to the Workers' Compensation Administrator.

## Your Employment Status

Except as limited below, if you are absent from your regular occupation for 12 months, you will be administratively separated from employment, regardless of your status on STD or LTD.

You must return to your regular occupation or any position provided as a reasonable accommodation under the Americans With Disabilities Act (ADA) (or state equivalent) for at least 30 calendar days before a new 12-month period will begin. Time spent performing modified work under the Residual Disability Program is not provided as a reasonable accommodation under the ADA (or state equivalent); thus such time is considered an absence and does not extend this 12-month period. For example, if your disability begins July 15, 2009, you will be administratively separated July 14, 2010.

If your disability should end after your separation and you are able to return to work, you will be considered for employment based on your experience and skills, as would any other applicant.

## Reasonable Accommodation Assessment

If, during your 12-month absence, you have requested an accommodation (or UPS has enough information to already know that an accommodation may be necessary) under the ADA (or state equivalent), you will be referred to a Human Resources representative responsible for ADA (or state equivalent) compliance to

determine whether you are eligible for an accommodation under applicable law and, if so, whether a reasonable accommodation is available (refer to the *UPS Equal Opportunity Statement*, available at [www.UPSers.com](http://www.UPSers.com)).

If an accommodation request is being processed at the 12-month date, an administrative termination will not occur, and health care coverage under The Flexible Benefits Plan will continue, until a decision has been made regarding the accommodation request. Once the 12-month date has passed, you will be administratively separated if you fail to participate in the interactive process or at such time as UPS has determined that no reasonable accommodation is available or that providing an accommodation would be an undue burden.

## Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details on the Plan's right of recovery provisions.

## How to File a Claim

See the *Filing a Claim* section.

## Filing a Claim

This section reviews what you need to do to file claims for the different benefit options in The Flexible Benefits Plan. If you have any questions about filing claims, please call the appropriate carrier.

### Medical

#### *When to File a Claim*

If you participate in the Traditional PPO or Healthy Savings PPO medical option and receive care through network providers, you generally won't have to worry about filing medical claims. On your first visit to your network provider, you'll sign a form to assign benefits. For subsequent visits, your network provider will take care of claims for you.

You will be responsible for filing your own claims if you use providers not participating in the network, although some out-of-network providers will file claims on your behalf.

You should file medical claims as soon as possible after the date you are billed. If your medical claim is not received within 12 months after the date the service or treatment was provided, no benefits will be paid.

#### *Completing a Medical Claim Form*

If you are required to file your own claims, the claim form must be completed by you and the provider of services. Complete the form in full. You can either attach itemized bills or have your doctor complete the physician's section of the form.

Send the completed form to your claims administrator at one of the addresses shown below:

Aetna  
PO Box 14079  
Lexington, KY 40512-4079

UnitedHealthcare  
PO Box 740800  
Atlanta, GA 30374-0800

### Behavioral Health

If your provider does not file a claim for you, send your invoice to:

ValueOptions  
PO Box 1347  
Latham, NY 12110-8847

If you have a question about a claim, you may call 1-800-UPS-1508.

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### Prescription Drugs

The procedure for filing prescription drug claims depends on whether you fill your prescription at a Medco retail pharmacy or through the Medco By Mail program.

Claims must be received within 12 months from the date the service or treatment is given, or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

#### *At a Participating Pharmacy*

If you fill your prescription at a participating Medco retail pharmacy, you do not have to file a claim form. You simply present your Medco ID card and pay your share of the cost at the pharmacy.

#### *At a Non-Participating Pharmacy*

If you use a non-participating pharmacy, fail to present your Medco ID card or have transition coverage, you must pay the full amount of your prescription and then submit a completed claim form for reimbursement. Claim forms are available

at [www.medco.com](http://www.medco.com) or by calling Medco at 1-800-346-1327. Mail the completed form to:

Medco Health Solutions of Dallas  
PO Box 650322  
Dallas, TX 75265-0322

### **Medco By Mail Program**

You don't file claim forms if you fill your maintenance drug prescriptions through the Medco by Mail program. To order drugs through the program, send your prescription with your coinsurance (if payment is necessary), a Medco mail order form and your patient questionnaire (if you're a first-time user) to the address on the order form. Mail order forms and patient questionnaires are available at [www.medco.com](http://www.medco.com).

Your prescription will be immediately filled and sent to you. You will not be charged for shipping costs.

### **Dental**

If you seek care from an Aetna Dental PPO participating provider, the provider will submit your claim to Aetna. If you use a non-participating dentist, you may be required to submit your itemized statement with a claim form. You may obtain a claim form by calling 1-800-UPS-1508. Send the completed claim form to:

Aetna  
PO Box 14094  
Lexington, KY 40512-4094

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### **Vision**

If you use a VSP provider, your provider will file all necessary claim forms.

If you use a non-VSP provider, you must pay the full amount of the charges and then submit a completed claim form for reimbursement. Claim forms are available at [www.vsp.com](http://www.vsp.com) or by calling VSP at 1-800-877-7195. Mail the completed form to:

Vision Service Plan  
3333 Quality Drive  
Rancho Cordova, CA 95670

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### **Tax-Advantaged Reimbursement Accounts**

Streamlined claims submission and/or direct deposit may be available for convenient reimbursement of your eligible HCSA, LPSA and C/ECSA expenses. See the *Tax-Advantaged Reimbursement Accounts* section of this book for complete information, including how to enroll.

If you choose not to participate in streamlined claims submission and direct deposit, or have expenses that cannot be streamlined, claim forms for the HCSA, LPSA and C/ECSA tax-advantaged reimbursement accounts are available at [www.aetna.com](http://www.aetna.com) or by calling Aetna Member Services. Complete and return the form together with the required substantiation to the address below, or fax to 1-888-238-3539 (1-800-AET-FLEX).

Aetna FSA  
PO Box 4000  
Richmond, KY 40476-4000

## Filing a Claim (cont.)

### Life Insurance and AD&D

Contact Prudential Life Insurance Company at 1-877-877-2955 for information about filing life insurance and AD&D claims. Claims must be received by Prudential within 12 months of the date of the death or accident, or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

### Short-Term Disability

If you become unable to work because of an injury or illness, you may file a claim online from a link at [www.UPSers.com](http://www.UPSers.com), or go directly to [www.wkabsystem.com](http://www.wkabsystem.com). Enter UPS as the Company Identifier and your employee ID as the User ID. When you first access this site, you'll need to click *New User Registration* and choose a password that you will enter each time you visit the site. Or, call 1-800-UPS-1508 to reach a representative from Aetna Disability and Absence Management (ADAM), the STD claims administrator. The ADAM representative will:

- Ask you for information:
    - Name and address of UPS, date of hire and supervisor's name and phone number
    - Your name, phone number, home address and Employee ID or Social Security number
    - The date of your injury or illness and the first day you were absent from work
    - Your doctor's name, address and phone number, the date you were first treated for this condition, and your next appointment
  - Verify how you became disabled
  - Explain the STD claim process, including the need to obtain medical information from your doctor
- The representative will send you a release form that allows ADAM to obtain information about your condition. Your claim will then be assigned to a case manager, who will assist you in gathering the required documentation from your doctor. If you do not return the release and reimbursement forms in the time specified, you may not be eligible for benefits. **It is your responsibility to obtain and submit clinical medical information to ADAM that supports your disability.**
- If you are an Administrative or Technical employee, contact ADAM at the end of your applicable waiting period.
- If you are a Management or Specialist employee, contact ADAM at the end of two weeks. If you do not call at the end of two weeks, your regular UPS paycheck may be interrupted, since ADAM must notify UPS to continue your pay.
- In any case, claims must be received (via phone or Web) within 60 days of the initial date of disability in order to receive STD benefits.
- **If your claim is approved**, you will receive an approval letter providing you a number to call if you have questions about your coverage, and indicating your expected return-to-work date. ADAM will notify UPS of your anticipated return-to-work date and your claim approval. You should receive your first weekly payment within two weeks (if you are an Administrative or Technical employee) from the date your claim is approved.
  - **If your claim is denied**, you'll receive a letter providing specific reasons for the denial, with specific instructions for how to appeal the denial. (See the *If a Claim is Denied* section for more information.) ADAM will notify UPS that your claim has been denied. You should contact your manager to schedule your return to work.



## Long-Term Disability

If you have been receiving STD benefits and qualify for LTD, your case manager will automatically refer your case to MetLife, the LTD claims administrator, for determination of LTD eligibility. If you do not have a case manager, contact MetLife at 1-877-638-4877 or online at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) to file your claim.

Remember that, while STD benefits are paid weekly, LTD benefits are paid monthly, near the end of each month.

## Adoption Assistance

Eligible expenses are reimbursed after legal custody is obtained from a court of law. Follow these steps to file for reimbursement:

- Contact the Benefits Service Center at 1-800-UPS-1508 to request an Adoption Assistance Reimbursement form
- Complete the form and attach all itemized bills and legal documentation (must be translated into English if an international adoption)
- Send the form and documentation to:  
Adoption Assistance Program  
United Parcel Service  
55 Glenlake Parkway, NE  
Atlanta, GA 30328

Once reimbursement is approved, you will receive a check from your local Human Resources representative with applicable taxes deducted. Allow three weeks for processing your reimbursement request.

Claims must be received within 12 months after the date of legal custody or no benefits will be paid. Any reimbursement checks that are not cashed within 12 months from the date of the check are void and you lose any rights to such reimbursement.

## Right of Recovery Provision

This section describes the Plan's right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your covered dependents (referred to in this section as a "covered individual") if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below.

If a covered individual incurs expenses covered by the Plan as a result of the act of a third party (person or entity) you may receive benefits pursuant to the terms of the Plan. However, the covered individual shall be required to refund to the Plan all benefits paid if the covered individual receives any recovery from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The covered individual may be required to:

1. Execute an agreement provided by UPS ("the Company") or the claims administrator acknowledging the Plan's right of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the covered individual from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the covered individual's cause of action or other right of recovery to the Plan. If the covered individual fails to execute such an agreement, by filing claims (assigning benefits or having claims filed on your behalf) related to such act of a third party, the covered individual shall be deemed to agree to the terms of this reimbursement provision;
2. Provide such information as UPS or claims administrator may request;

## Filing a Claim (cont.)

3. Notify UPS and/or the claims administrator in writing by copy of the complaint or other pleading of the commencement of any action by the covered individual to recover damages from a third party;
4. Agree to notify UPS and/or the claims administrator of any recovery.

The Plan's right to recover the benefits it has paid is subject to reduction for attorney's fees and other expenses of recovery. The reduction is limited to the lesser of actual attorney fees and other expenses or one-third of the Plan's lien. The Plan's right to recover benefits shall apply to the entire proceeds of any recovery by the covered individual. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (in other words, the Plan has a right of first reimbursement out of any recovery, even if the covered individual is not fully compensated), or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the covered individual and against future benefits due under the Plan in the amount of any claims paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any covered individual that could be subject to the Plan's right of recovery if and when received by the covered individual. If the covered individual fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

If the covered individual fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment

or subrogation, a portion of the covered individual's claim equal to the amounts the Plan has paid on the covered individual's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year, nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

The covered individual shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the covered individual against a responsible third party and the giving of testimony in any action filed by the Plan. If a covered individual fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (for example, income protection plan benefits paid to a person who does not qualify for benefits) or benefits that were obtained through fraudulence, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.

## Maintenance of Benefits

*This provision applies to medical (excluding prescription drugs), behavioral health, dental and vision benefits only.*

The Flexible Benefits Plan has a maintenance of benefits provision. Under this provision, benefits from the Plan option you select, when added to the benefits paid by another



group plan for the same services, will not exceed the amounts that would have been paid by the UPS option you select if you had been covered only by the Plan. If a person is covered by two plans, one of the plans is considered primary and the other is considered secondary. When a claim is made, the primary plan pays benefits first.

### ***Determining Which Plan is Primary***

A plan without a maintenance of benefits or coordination of benefits provision is always the primary plan. If all plans have one of these provisions, the primary plan will be determined in this order:

1. The plan covering the person as an employee rather than the plan covering the person as a dependent (or a qualified beneficiary under COBRA) is primary.
2. The plan covering the person as a dependent rather than the plan covering the person as a qualified beneficiary under COBRA is primary.
3. If a person is covered as an employee by two plans, the plan covering the person the longest is the primary plan.
4. If a part-time employee is also covered as a result of full-time employment, the plan offering coverage as a result of full-time employment is primary.
5. If a child is covered by both parents' plans, the plan of the parent whose birthday falls first in the calendar year is considered the primary plan.
6. In the case of divorce or separation:
  - A. The plan covering the child as a dependent of the parent legally declared financially responsible by court decree is primary.
  - B. The plan covering the parent who has custody of the child (if there is no court decree) is primary.

C. In the event there is no court decree and the parent who has custody has remarried, the order of priority is:

1. The plan covering the parent who has custody is primary.
2. The plan covering the spouse of the parent who has custody is primary.
3. The plan covering the parent without custody is primary.

When a determination cannot be made, the plan covering the eligible dependent longer is considered primary.

If the Plan is secondary in accordance with these provisions, but the primary plan attempts to reduce its responsibility under the primary plan solely because you or your family is covered under another plan, the Plan will only pay benefits under this Plan, in accordance with the maintenance provisions of this Plan, as though the primary plan paid benefits without regard to other coverage you may have.

The Plan Administrator has sole discretion to determine the amount that the primary plan would have paid, taking into account the other plan's governing documents.

Any other situation will be handled in accordance with guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

### ***Maintenance of Benefits Example***

To show how maintenance of benefits works, consider this example.

- Your spouse is covered by another plan (let's call it "Plan A") that is primary and also covered by The Flexible Benefits Plan (let's call it the "Flex Plan"), which is secondary.
- Your spouse has covered expenses of \$100.
- Plan A would pay benefits of \$75 and the Flex Plan would pay benefits of \$90.

## Filing a Claim (cont.)

Since the other plan is primary:

- Your spouse will receive \$75 from Plan A first.
- The Flex Plan will pay an additional \$15 to make the total reimbursement \$90, or the amount that would have been paid by the Flex Plan if there were no other coverage.
- However, if Plan A had paid \$95 and the Flex Plan would have paid only \$90, Plan A would not pay any additional amount because the benefit paid by Plan A exceeds the Flex Plan's benefit amount.

When calculating what you have to pay, remember that a health care provider may be a participant in one plan's network but not the other. This affects the amount of benefits payable from the plan in which an out-of-network benefit is paid. So if your spouse's plan is primary, and she has an office visit to a doctor who participates in her medical plan network but not in your Plan's network, for purposes of the maintenance of benefits provision, that visit will be considered an out-of-network expense by the Plan.

### Coordination with Medicare

Medicare benefits will be primary to the extent permitted under applicable law. In the event that Medicare is the primary payor, the Plan is secondary and assumes that you are enrolled in Medicare Parts A, B, and D.

As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the Plan pays benefits first, or whether Medicare is primary.

### Coordination of Flexible Benefits Plan

Medicare-covered individuals who are also covered under The Flexible Benefits Plan based on criteria other than current employment status (for example, participants continuing coverage under COBRA

and certain disabled employees) will have Medicare as their primary coverage. Individuals with end stage renal disease (ESRD) may be subject to a coordination period during which The Flexible Benefits Plan is primary, after which Medicare becomes primary.

If you are an active employee covered by The Flexible Benefits Plan, this Plan is primary for you and any covered dependents who are eligible for Medicare (for example, due to a disability or being age 65 or older).

If you are disabled (as determined by the STD or LTD claims administrator) and not actively at work, the Plan is primary for you and/or any covered dependents who are eligible for Medicare during the period that you are considered to be in "current employment status" by Medicare secondary rules (which is usually no longer than the first six months that you are receiving disability benefits from the Plan).

### Coordination of End Stage Renal Disease (ESRD) Coverage

In the event a covered individual is eligible for Medicare due to end stage renal disease (ESRD)\* and is covered by The Flexible Benefits Plan, the Plan is primary during the coordination period (currently the first 30 months of ESRD). During the time the Plan pays benefits first, you should submit a claim for any remaining expenses not covered by the Plan to Medicare.

After the coordination period, Medicare is primary. During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

Apart from the above, the Plan will coordinate with Medicare as permitted under applicable law.

*\*Incidentally, you should apply for Social Security disability income benefits as soon as possible to make sure you have no gaps in income protection.*

## If a Claim Is Denied

If your claim for benefits under the Plan is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is.

### Denial of Insured or Third-Party Benefit Claims

Certain benefits offered under the Plan are provided through an insurance contract issued to UPS (“the Company”) by an insurance carrier. In this case, the insurance carrier is the applicable claims fiduciary with respect to claims for benefits provided under the insurance contract. This means that the insurance carrier — not the UPS Claims Review Committee (“the Committee”) — has the discretionary authority to determine benefits that are insured by the insurance carrier.

In addition, MetLife is the claims fiduciary with respect to claims for long-term disability benefits.

If your claim for an insured or third-party benefit is denied under the Plan, you should refer to the applicable policy or Certificate of Coverage provided by the carrier, or contact the insurance carrier for more information on the applicable claims procedures.

For each of the benefits listed below, you should file any appeals with the insurance carrier (**not** with the Committee). Contact your insurance carrier for more information about filing appeals.

- Aetna Dental DMO
- Kaiser Permanente HMO
- Prudential Life insurance and AD&D
- Legal plan (Hyatt)
- Personal lines of insurance (Liberty Mutual, MetLife)
- Critical illness (MetLife)
- Long-term care (MetLife)
- EAP (ValueOptions)
- Long-term disability (MetLife)
- Quit For Life (Free & Clear)

### Denial of Non-Insured Benefit Claims

If the benefit is not provided through an insurance contract and it is not a long-term disability claim, if your claim is denied you may choose to file an appeal with the claims administrator. Contact your claims administrator’s Member Services (see Member Services on the back page of this booklet) for the mailing address to use when filing appeals.

If your first-level appeal is denied, you may choose to file a second-level appeal with the UPS Claims Review Committee (“the Committee”). The decision of the Committee is final.

Non-insured benefits of The Flexible Benefits Plan are listed below.

- Medical
- Behavioral health
- Prescription drugs
- Vision
- Health Care Spending Account (HCSA)
- Limited Purpose Spending Account (LPSA)
- Child/Elder Care Spending Account (C/ECSA)
- Dental Option 1 or Option 2
- Short-term disability
- Adoption Assistance

The claims review procedures that follow in this section will apply to all non-insured benefit claims.

### Group Health Benefit Plans

The Plan has established special claims review procedures for medical, behavioral health, prescription drugs, dental, vision, HCSA and LPSA benefits (called “group health benefit plans”). The claims review procedures vary depending on the type of claim you have.

## If a Claim Is Denied (cont.)

### Types of Group Health Benefit Plan Claims

There are three types of claims: Pre-Service, Concurrent Care and Post-Service Claims. Also, certain pre-service or concurrent care claims may involve “urgent care.”

**Pre-Service Claim.** A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you obtain preauthorization for most hospital admissions.

**Concurrent Care Claim.** A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

**Post-Service Claim.** A claim for:

- Care that has already been received
- Any claim for which the Plan does not require preauthorization
- Health Care Spending Account (HCSA) and Limited Purpose Spending Account (LPSA)

**Urgent Care Claims.** A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine, or a physician with knowledge of the claimant’s medical condition), or
- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant’s condition)

### Appeals Procedures for Group Health Benefit Plan Claims

Generally, the steps below describe your appeal procedures, regardless of the type of claim. A claim is not deemed “filed” for purposes of these claims review procedures until it is filed in accordance with the *Filing a Claim* section of this SPD and it is received by the claims administrator or, where applicable, the UPS Claims Review Committee.

The following provides additional detail about how your claims appeals are processed for all benefits that are not insured:

- Each level of appeal will be independent from the previous level (in other words, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal)
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim
- If a claim involves medical judgment, then the claims administrator and the Claims Review Committee will consult, during the first and second level appeal, with a health care professional who has expertise in the specific area involving medical judgment
- You cannot file suit in federal court until you have exhausted these appeals procedures

**Step 1: Notice of denial is received from claims administrator.** If your claim (or preauthorization request) is denied, you will receive written notice from the claims administrator that your claim is denied

(in the case of urgent claims, notice may be oral). The time frame in which you will receive this notice is described in the *Claims and Appeals Procedures Table* and will vary depending on the type of claim. In addition, the claims administrator may request an extension of time in which to review your claim for reasons beyond the claims administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the claims administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

**Step 2: Review your notice of denial carefully.** Once you have received your notice from the claims administrator, review it carefully. The notice will contain:

- a. The reason(s) for the denial and the Plan provisions on which the denial is based;
- b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- c. A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your final appeal;
- d. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;

- e. If the denial is based on a medical necessity, experimental treatment or a similar Plan exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request; and
- f. If the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

**Step 3: If you disagree with the decision, file a first level appeal with the claims administrator.** If you do not agree with the decision of the claims administrator and you wish to appeal, you must file a written appeal with the claims administrator within 180 days of receipt of the claims administrator's letter (or oral notice if an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally. In addition, you should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

**Step 4: You receive a notice of the first level appeal from the claims administrator.** If the claim is again denied, you will be notified by the claims administrator within the time period described in the *Claims and Appeals Procedures Table*, depending on the type of claim.

**Step 5: Review your first level appeal notice carefully.** You should take the same action you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the claims administrator (see Step 2).



## If a Claim Is Denied (cont.)

**Step 6:** If you still disagree with the claims administrator's decision, file a second level appeal with the Committee. If you still do not agree with the claims administrator's decision and you wish to appeal, you must file a written second (and final) level appeal to the Committee within 60 days after receiving the first level appeal denial notice from the claims administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. The appeal should be sent to:

UPS Claims Review Committee  
55 Glenlake Parkway, NE  
Atlanta, GA 30328

**Step 7: Review your second level appeal notice carefully.** If the Committee denies your second level appeal, you will receive notice within the time period described in the *Claims and Appeals Procedures Table*, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 2 above, including your right to bring a civil action following a denial of your final appeal.

## Appeals Procedures for Other Types of Non-Insured Claims

### *For Short-Term Disability Claims*

The same steps described above for group health benefit plan claims apply to short-term disability (STD) claims filed under the Income Protection Plan, including claims related to a failure to meet timely filing requirements. However, the time periods for making a decision for disability claims are different. Refer to the *Claims and Appeals Procedures Table* in this section for details.

### *For C/ECSA or Adoption Assistance Claims*

The same steps described above for group health benefit plan claims apply to Child/Elder Care Spending Account (C/ECSA) or adoption assistance benefits, within the time periods described in the *Claims and Appeals Procedures Table* in this section.

The claims administrator for the adoption assistance program is UPS; for this reason, the UPS Claims Review Committee reviews both first level and second level appeals, following strict guidelines established by ERISA.

## Limitation on Legal Action

Any legal action to receive Plan benefits must be filed the earlier of:

- Six months from the date a determination is made under the Plan or should have been made in accordance with the Plan's claims review procedures, or
- Three years from the date the service or treatment was provided or the date the claim arose, whichever is earlier. Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

## Claims and Appeals Procedures Table

The table on the following page shows the time limit for you to submit appeals, and for the claims administrator or UPS Claims Review Committee to respond to your appeal. This table is intended to be used in conjunction with the remainder of information in this section.



**Claims and Appeals Procedures**

Type of Claim	Initial Claims			1st Level Appeal		2nd Level Appeal	
	<i>You'll be notified of determination as soon as possible but no later than...</i>	<i>Extension period* allowed for circumstances beyond claims administrator's control...</i>	<i>If additional information is needed, you must provide within...</i>	<i>You must file your appeal within...</i>	<i>You'll be notified of determination as soon as possible but no later than...</i>	<i>You must file your appeal within...</i>	<i>You'll be notified of determination as soon as possible but no later than...</i>
<b>Group Health Benefit Plans</b>							
Pre-Service	15 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	15 days from receipt of appeal	60 days of 1st level appeal denial	15 days from receipt of appeal
Pre-Service involving Urgent Care	72 hours (24 hours if additional information is needed from you)	None	48 hours (claims administrator must notify you of determination within 48 hours of receipt of your information)	180 days of claim denial	72 hours from receipt of appeal	N/A	N/A
Concurrent: To end or reduce treatment prematurely	Notification to end or reduce will allow time to finalize appeal before end of treatment	N/A	N/A	(Denial letter will specify filing limit)	15 days from receipt of appeal	(Denial letter will specify filing limit)	15 days from receipt of appeal
Concurrent: To deny your request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim
Concurrent: Involving Urgent Care	24 hours, if claim submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care	None	N/A	180 days of claim denial	72 hours from receipt of appeal	N/A	N/A
Post-Service	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	30 days from receipt of appeal	60 days of 1st level appeal denial	30 days from receipt of appeal
<b>Other Non-Insured Benefits</b>							
C/ECSA and Adoption Assistance	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	30 days from receipt of appeal	60 days of 1st level appeal denial	30 days from receipt of appeal
Short-Term Disability (STD)	45 days from receipt of claim	Two extensions of 30 days each	45 days of date of extension notice	180 days of claim denial	45 days from receipt of appeal (with one 45-day extension for reasons beyond the Plan's control); you must submit requested documentation within 45 days	60 days of 1st level appeal denial	45 days from receipt of appeal (with one 45-day extension for reasons beyond the Plan's control)

\*The extension period is measured from the end of the original determination due date.

### Notifying the COBRA Administrator

*If you are required to notify the COBRA administrator, as indicated within this section and elsewhere in the SPD, you must call the Benefits Service Center at 1-800-UPS-1508.*

## Continuation of Coverage under COBRA

In certain circumstances, health care coverage for you and your dependents (if Qualified Beneficiaries) can continue beyond the date it would otherwise end. This continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A “qualified beneficiary” is an employee, spouse and/or dependent child who has health coverage under this Plan immediately preceding a qualifying event. A child born to or adopted by (or placed for adoption with) a covered employee during a continuation period is also a qualified beneficiary, provided the child is added to coverage within 60 days of the birth, adoption or placement for adoption. Qualified beneficiaries have independent COBRA election rights and can elect to continue group health plan coverage for themselves even if you (the covered employee) choose to decline coverage.

The information included here is a general overview of COBRA provisions. If you become eligible for continued coverage (that is, if you have a qualifying event),

you’ll be given more information that reflects your situation at the time.

### How COBRA Works

Eligibility for COBRA is triggered by a “qualifying event.” The following table describes the types of qualifying events and the maximum length of coverage available for each event. The maximum coverage period is measured from the date of the qualifying event, except as otherwise stated in this booklet.

If you decide to continue coverage, you must pay the full cost of that coverage, plus a two percent administrative cost. The monthly premium amount will be provided to you once a qualifying event occurs.

The initial premium must be paid within 45 days of your enrollment date (there is no grace period). Subsequent premiums are due on the first of each month. Failure to make subsequent payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.

Qualifying Events	Continuation of Coverage		
	You	Your dependent spouse	Your dependent child
You terminate UPS employment before retiring	18 months	18 months	18 months
Your work hours are reduced*	18 months	18 months	18 months
You retire	18 months	18 months	18 months
You become divorced or legally separated	N/A	36 months	N/A
Your child ceases to be a qualified dependent	N/A	N/A	36 months
You die**	N/A	36 months	36 months

*\*And, as a result, you’re ineligible for health care coverage. Your 18 months of COBRA coverage follows the 12-month extension of coverage while on STD or LTD.*

*\*\*The 13-month UPS-paid extension period is included as part of the 36-month maximum coverage period (see What If...You Die in the Life Events section).*

Continued coverage will usually be available for either 18 or 36 months. If you are on approved military leave that lasts longer than 30 days, your coverage may last up to 24 months or until the date that you fail to return to work (as required by USERRA — see *What If...You Take an Approved Leave of Absence/Military Leave* in the *Life Events* section).

If you (or a qualified beneficiary) are disabled at the time (or within 60 days from the time) you terminate employment or have a reduction in hours, you may extend COBRA coverage for an additional 11 months, for a total of 29 months. This coverage is available at 150 percent of the applicable premium. To be eligible for this extension, you (or the qualified beneficiary) must:

- Receive a determination of disability from the Social Security Administration (SSA), and
- Notify the Benefits Service Center of the determination within the earlier of the 60-day notice period or the 18-month period.\* The 60-day notice period ends 60 days after the latest of:
  - The qualifying event
  - The date coverage is lost as a result of the qualifying event, or
  - The date of determination by the Social Security Administration.

*\*In addition, the notice must be provided before the end of the 18-month COBRA period without regard to the 60-day notice period. If you receive the Social Security Administration determination with only two weeks left in your 18-month COBRA period, you have only two weeks to provide the notice.*

If during the 11-month extension you're no longer considered disabled by the Social Security Administration, you

must notify the Benefits Service Center at 1-800-UPS-1508 within 30 days of this determination. COBRA coverage may then continue up to the first day of the month that starts more than 30 days after the Social Security Administration's decision; or the date coverage would otherwise end, if earlier.

A qualified beneficiary (other than a covered employee) may extend an 18- or 29-month continuation period up to a total of 36 months if they experience one of the following qualifying events during the 18- or 29- month COBRA period. The COBRA Administrator must be notified within 60 days of the date of the event.

- Divorce or legal separation
- Child ceasing to be a dependent child
- Covered employee becomes entitled to Medicare
- Death of the covered employee

These may result in an extension of coverage only if you provide notice and the event would otherwise cause a loss of coverage under the Plan for active employees and their dependents. For example, Medicare entitlement will not result in the loss of active coverage under the Plan.

If a covered employee becomes entitled to Medicare while an active employee and then loses coverage as a result of termination or a reduction in work hours **within 18 months** of becoming entitled to Medicare, a qualified beneficiary other than the covered employee is eligible for 36 months of continued coverage (counted from the date that the covered employee became entitled to Medicare).

### The 60-Day Notice

*If you do not notify the Benefits Service Center at 1-800-UPS-1508 within 60 days of a divorce, legal separation or loss of dependent status (not due to age), you (or the qualified beneficiary) forfeit your right to COBRA coverage.*

## Continuation of Coverage under COBRA (cont.)

However, your continued coverage will end sooner if any of the following occurs:

- The premium for continued coverage is not paid
- You become entitled to Medicare after electing COBRA coverage (not applicable to an employee on military leave)
- You become covered by another health care plan after electing COBRA coverage (not applicable to an employee on military leave, and except where the person is subject to a pre-existing condition)
- UPS terminates all group health care plans, or
- Your coverage would be terminated as an active employee for any other reason.

### COBRA Notification Deadline

In most cases, you'll be notified when you become entitled to continue health care coverage. However, for other events, you or your dependent should notify the Benefits Service Center immediately. You must notify the Benefits Service Center within

60 days of the qualifying event (or the date you would otherwise lose coverage as a result of the qualifying event), or continued coverage will not be available. The chart below shows when UPS will automatically send COBRA enrollment materials and when you or your dependent must notify the Benefits Service Center.

### Enrollment in COBRA

As with active employees, there are two types of enrollment: initial enrollment when you first become eligible, and annual enrollment.

#### Initial Enrollment

When you become eligible for COBRA, you and your covered eligible dependents may each independently choose to continue medical, dental and vision coverage for up to the entire coverage period. You may choose to continue the Health Care Spending Account (HCSA) or Limited Purpose Spending Account (LPSA) on an after-tax basis until the end of that

#### Event

- Termination
- Retirement
- Layoff
- Death of employee
- Transfer to ineligible position
- Personal leave of absence
- Reaching 12 months on leave of absence
- Loss of dependent status due to age
- Divorce
- Legal separation
- Loss of dependent status not due to age

#### Responsible for Notification

Benefits Service Center will automatically send your COBRA enrollment materials to the employee's address on file.

You or the qualified beneficiary should call the Benefits Service Center at 1-800-UPS-1508 immediately. If you do not notify the Benefits Service Center within the 60 days, you (or the qualified beneficiary) forfeit any right to COBRA coverage.

calendar year. You must make your election within 60 days of the date of your enrollment notice, or the date coverage is lost if later.

During initial COBRA enrollment, you may not make changes to your medical, dental or vision options (for example, changing from Dental Option 1 to Dental Option 2) except to stop coverage (for example, electing not to have dental coverage but to keep medical and vision). You may, however, decrease your coverage category (meaning you only, you plus spouse, you plus children or you plus family).

A change in status at the time of your qualifying event may allow you to change certain coverage during initial COBRA enrollment (See the *Life Events* section for more information).

### ***Annual Enrollment***

At each annual enrollment, you can make new choices by calling the Benefits Service Center at 1-800-UPS-1508.

### ***Life Events***

During a COBRA continuation period, coverage may be modified based on Plan rules if you experience a change in status. See the *Life Events* section for details on allowable changes in status.

If a spouse is dropped from coverage during annual enrollment and later becomes divorced or legally separated from the covered employee, the spouse may be entitled to COBRA continuation coverage if the termination of coverage is deemed by the Plan Administrator to be “in anticipation of” the divorce or legal separation

and the former spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation.

## **The COBRA Administrator**

The Benefits Service Center is the COBRA administrator and will handle all COBRA enrollment and billing. The Benefits Service Center can be reached at 1-800-UPS-1508.

## **Your Right to Obtain Individual Coverage**

A federal law, Health Insurance Portability and Accountability Act (HIPAA), requires all health insurance carriers offering coverage in the individual market to accept any eligible individuals who apply for coverage, without imposing a pre-existing condition exclusion. To take advantage of this HIPAA right you must complete your 18-, 29- or 36-month COBRA coverage period under The Flexible Benefits Plan and apply for coverage with an individual carrier before you have a 63-day lapse in coverage. Since this coverage is not sponsored by UPS, you should contact your state’s department or commission of insurance or see your independent insurance specialist to secure coverage.

## ERISA and Other Important Information

### Plan Administration

The information contained in this book, including the schedule of benefits, is a summary of the applicable administrative and legal documents relating to The Flexible Benefits Plan. For insured benefits, in the event there is any difference between this book and the applicable contracts or certificates, the insurance documents will govern.

United Parcel Service, as Plan Administrator, shall have the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plan. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plan's terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more persons, entities, and/or committees. The Plan Administrator has designated claims fiduciary authority and discretion to the UPS Claims Review Committee and MetLife (as noted in the *Filing a Claim* section of this booklet).

Your participation in The Flexible Benefits Plan does not guarantee your continued employment with UPS. If you quit, are discharged or laid off, the Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan document.

All benefits described in this book — both for you and your family — are paid for by you and UPS, and are made available to you as part of the Total Rewards Program you receive or received for your work with UPS. Kaiser HMOs, Aetna DMOs, LTD, life insurance, accidental death and dismemberment insurance, personal lines of insurance, the legal plan, critical illness insurance and long-term care benefits are provided to Flexible Benefits Plan participants by means of insurance contracts, for which you and/or UPS pay the premiums. STD benefits for exempt employees are paid from Company assets. With regard to the Plan's other benefits, UPS has established a special trust, called a voluntary employee beneficiary association (VEBA) trust, to serve as the funding vehicle. All contributions to the trust are made from the general assets of UPS and its affiliated Companies. Depending on the coverage you elect, you may be required to pay a portion of the cost of providing those benefits.

Your coinsurance and/or deductible amounts under the Plan may be determined before application of any allowances, incentives and/or other adjustments to which the Plan may be entitled. All allowances, incentives and/or other adjustments are retained by the Plan to be used as permitted under applicable law.

The Plan Administrator is United Parcel Service, which is authorized to delegate its administrative duties to one or more individuals or committees within UPS, or to one or more outside administrative service providers. Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided under contract as follows.



<b>Medical coverage is administered by the following:</b>	Aetna 151 Farmington Avenue Hartford, CT 06156
	Kaiser Permanente 1950 Franklin Oakland, CA 94604
	UnitedHealthcare (Uniprise) 9900 Bren Road East Minnetonka, MN 55343
<b>Behavioral health and Employee Assistance Program is administered by:</b>	ValueOptions 1199 S. Beltline Road, Suite 100 Coppell, TX 75019
<b>Quit For Life tobacco cessation program is administered by:</b>	Free & Clear®, Inc. 999 Third Avenue, Suite 2100 Seattle, WA 98104
<b>Prescription drug coverage is administered by:</b>	Medco Health Solutions 100 Parsons Pond Drive Fair Lawn, NJ 07410
<b>Dental coverage is administered by:</b>	Aetna 151 Farmington Avenue Hartford, CT 06156
<b>Vision coverage is administered by:</b>	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
<b>Legal coverage is administered by:</b>	Hyatt Legal Plans 1111 Superior Avenue Cleveland, OH 44114
<b>Personal Lines (auto and home insurance) coverage is administered by:</b>	Liberty Mutual 175 Berkeley Street Boston, MA 02117
	Metropolitan Property and Casualty Insurance Company c/o MetLife Voluntary Benefits Group Sales 10 South LaSalle Street, Suite 3350 Chicago, IL 60603
<b>Short-term disability is administered by:</b>	Aetna Disability Absence Management 1601 SW 80th Terrace Plantation, FL 33324
<b>Long-term disability is administered by:</b>	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166
<b>Health Care Spending Account, Limited Purpose Spending Account and Child/Elder Care Spending Accounts are administered by:</b>	Aetna 151 Farmington Avenue Hartford, CT 06156

## ERISA and Other Important Information (cont.)

<b>Health Savings Account is administered by:</b>	OptumHealth Bank PO Box 271629 Salt Lake City, UT 84127-1629
<b>Life and AD&amp;D Insurance are administered by:</b>	Prudential Life Insurance Company 751 Broad Street Newark, NJ 07102
<b>Long-Term Care and Critical Illness is administered by:</b>	MetLife — Long-Term Care Group PO Box 927 Westport, CT 06881-0937
<b>Adoption Assistance is administered by:</b>	UPS Adoption Assistance Program United Parcel Service of America, Inc. 55 Glenlake Parkway, NE Atlanta, GA 30328

### General Information

<b>Name of Plan:</b>	The Flexible Benefits Plan
<b>Plan Number:</b>	501
<b>Plan Year:</b>	January 1 through December 31
<b>Employer and Plan Sponsor:</b>	United Parcel Service of America, Inc. 55 Glenlake Parkway, NE Atlanta, GA 30328 404-828-6044
<b>VEBA Trustee:</b>	Boston Safe Deposit and Trust Company 135 Santilli Highway Everett, MA 02149
<b>Employer Identification Number (EIN):</b>	95-1732075
<b>Plan Administrator:</b>	The Flexible Benefits Plan United Parcel Service of America, Inc. 55 Glenlake Parkway, NE Atlanta, GA 30328

## Your ERISA Rights

The Flexible Benefits Plan is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the Plan, you have certain rights and protection under ERISA.

ERISA provides that, as a Plan participant, you are entitled to:

- **Receive information about your Plan and benefits.** You may examine, without charge, at the Plan Administrator's office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may charge a reasonable amount for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue group health plan coverage.** You may continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. You should review this summary plan description for information concerning your COBRA continuation coverage rights.

You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you move to another plan and you have creditable coverage from this Plan. The Flexible Benefits Plan does not contain any exclusionary periods of coverage for pre-existing conditions. You will be provided a certificate of creditable coverage, free of charge, from The Flexible Benefits Plan when:

- You lose coverage under the Plan
- You become entitled to elect COBRA continuation coverage
- Your COBRA continuation coverage ceases
- You request it before losing coverage, or
- You request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

- **Prudent actions by Plan fiduciaries.** In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

## ERISA and Other Important Information (cont.)

- **Enforce your rights.** If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For example, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.
- **Assistance with your questions.** If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA,

or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or:

Division of Technical Assistance  
and Inquiries  
Employee Benefits Security  
Administration  
U.S. Department of Labor  
200 Constitution Ave., NW  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### Plan Amendment or Termination

UPS has established this Plan with the expectation that it will be continued indefinitely. Nevertheless, UPS reserves the right to amend or terminate the Plan at any time. The right to amend or terminate each Plan applies to all coverage hereunder, including coverage for active, retired and disabled employees. No amendment or termination of either Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

### About This Booklet

This booklet as updated by any future summary of material modification, constitutes your Summary Plan Description (SPD) for The Flexible Benefits Plan. In addition, this SPD, as the official Plan document, governs the Plan. UPS reserves the right to amend or terminate the Plan or any portion of the Plan at any time.

[illegible]

## Notes

[illegible]



# The Flexible Benefits Plan

## Member Services



### UPSers.com

- The online link to all your benefits and more

[www.UPSers.com](http://www.UPSers.com)

My Life and Career tab

### eHR

- Toll-free phone access to all your benefits and vendors

1-800-UPS-1508

(Available 24 hours  
a day except Sundays  
1:00 a.m. to 12:00 noon CT)

### Benefits Service Center

- Enroll
- Verify eligibility
- Add or remove dependents
- Request benefits materials
- Inquire about COBRA

1-800-UPS-1508

(Representatives available  
8:00 a.m. to 8:00 p.m. CT  
Monday through Friday)

### Aetna

- Medical PPO
- Medical Out-of-Area
- Dental (all options)
- Short-term disability
- Reimbursement accounts

[www.aetna.com](http://www.aetna.com)

1-800-435-7324

1-800-237-0575

1-877-263-0659

1-866-825-0186

1-888-238-6226

[www.wkabsystem.com](http://www.wkabsystem.com)

### UnitedHealthcare

- Medical (all options)

[www.myuhc.com](http://www.myuhc.com)

1-877-838-7528

### Kaiser Permanente

- California
- Oahu
- Neighbor Islands

[www.kp.org](http://www.kp.org)

1-800-464-4000

432-5955

1-800-966-5955

### ValueOptions

- Behavioral health
- Employee Assistance Program (EAP)

[www.achievesolutions.net/ups](http://www.achievesolutions.net/ups)

1-800-336-9117

1-800-336-9117

### Medco

- Prescription drugs

[www.medco.com](http://www.medco.com)

1-800-346-1327

### Vision Service Plan (VSP)

- Vision

[www.vsp.com](http://www.vsp.com)

1-800-877-7195

### MetLife

- Long-term disability

[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

1-877-638-4877

### OptumHealth Bank

- Health Savings Account (HSA)

[www.optumhealthbank.com](http://www.optumhealthbank.com)

1-866-234-8913

### Prudential Insurance Company

- Life insurance and AD&D

1-877-877-2955

1-877-889-2070 (conversions only)

### Quit For Life

- Tobacco cessation program

1-866-QUIT-4-LIFE

# ENROLLMENT KIT

You Have a Lot to Protect



## UPS

### The Flexible Benefits Plan

Supplemental Term Life Insurance  
with Accidental Death & Dismemberment Insurance

Supplemental Dependent Term Life Insurance  
with Accidental Death & Dismemberment Insurance





# What’s Inside

- Why you may need more insurance ..... 4
- Why you should buy it at work..... 6
- How much you may need..... 7
- Plus, plan details and rate sheets

## Dear Valued Employee:

The Prudential Insurance Company of America (Prudential) knows how important it is to have enough life insurance coverage to protect your family from the unexpected. That's why United Parcel Service (UPS) selected Prudential—a name you know and trust—to be the provider of two valuable financial protection plans available to you and your dependents:

### **Supplemental Term Life Insurance with Accidental Death & Dismemberment Insurance**

### **Supplemental Dependent Term Life Insurance with Accidental Death & Dismemberment Insurance**

Both coverages provide extra security at competitive group rates.

A leading insurance carrier for 137 years, Prudential has financial strength ratings with A.M. Best, Moody's, Standard & Poor's, and Fitch.\* We have the resources and stability to honor long-term commitments—which means we'll be there when you need us.

Please take a few minutes to read through this booklet. It contains a general description of your Supplemental Term Life and Dependent Term Life plans and specific information about your coverage options and rates. Plus, there's information on the advantages of getting insurance at work, how much coverage you can get, and what it will cost. There's even a worksheet to help you figure out how much life insurance coverage you may need.

Please carefully review all of the information, so you can make an informed decision about participating in the program. If you have any questions, please call Prudential at **877-877-2955**.

Sincerely,

The Prudential Insurance Company of America

### **Think about this:**

If you participate in any sport, you wear the proper protective gear, not because you anticipate injury but to protect yourself—just in case. The same logic applies to purchasing life and accidental death & dismemberment insurance. No one anticipates an untimely death or a serious accident, but owning the right insurance helps protect your income, your family, and your future—just in case.



\*For up-to-date information about our ratings, please visit [www.investor.prudential.com](http://www.investor.prudential.com).

## “Why do I need life insurance?”

Life is full of pleasant surprises and, at the same time, life holds uncertainties. It's easier to plan for happy events you know will occur, and more difficult to plan for the unexpected—such as a death.

If you were no longer there to help support your family (immediate family, siblings, and parents), how would they be able to...

- **Pay off loans**—credit cards, mortgage, and auto?
- **Maintain their standard of living**—utilities, food, clothing, and personal expenses?
- **Provide for your children's future**—tuition and weddings?
- **Pay your final expenses**—medical care, burial, estate settlement, and inheritance taxes?

A sufficient amount of life insurance can help your family financially recover from your loss during a stressful time.

## “I already have life insurance—why do I need more?”

Because, like many people, your life insurance amount may be inadequate.

People who die prematurely without enough life insurance coverage create a financial burden for their surviving family. Approximately 45% of widows and 37% of widowers who responded to a recent survey said that their spouse, same-sex domestic partner, or civil union partner did not have adequate life insurance. The survey also revealed that one to two years after the death of a spouse, same-sex domestic partner, or civil union partner, almost half of the respondents were just getting by financially.\*

You may be underinsured if your salary has increased since you last purchased insurance. Plus, when you consider new family responsibilities and inflation, the life insurance coverage you have now may not offer enough protection for your family.

\*“The Need and Value of Life Insurance,” LIMRA, August 2004.

## “Why do I need accident insurance?”

You might be surprised to learn that, in the United States:

- A disabling injury occurs in the home every four seconds.\*
- A disabling injury is caused by a motor vehicle crash every 14 seconds.\*
- Accidents are the fifth leading cause of death.\*
- A fatal injury occurs every five minutes.†

While no one can prevent every accident, you can help protect yourself and your family from the financial drain of accidental injuries and death with extra coverage provided by Accidental Death & Dismemberment (AD&D) Insurance.

AD&D Insurance ensures coverage to help:

- Support your family (immediate family, siblings, and parents) with a lump sum payment following a covered accident.
- Transition your spouse, same-sex domestic partner, or civil union partner into the workplace by covering the cost of job training programs, if you die.
- Provide child day care, if you die.
- Pay for college tuition for your children, if you die.
- Pay you a benefit for loss of a limb resulting from a covered accident.

### Peace of Mind from Prudential

Prudential's resources, financial strength, and stability allow us to honor long-term commitments, which means that we'll be here when you and your family need us. We've been a top insurance provider for 137 years and have received positive insurance claims paying ratings from A.M. Best (A+), Moody's (A2), Standard & Poor's (AA-), and Fitch (A+).‡

Plus, we have the advanced technology and caring professionals to provide your beneficiaries with the kind of customer support they want and deserve. Our Customer Service Representatives are well-trained, knowledgeable professionals who can quickly answer your family's questions.

By choosing Prudential, you give yourself peace of mind, knowing you are providing for your loved ones.

‡ As of February 2012. A.M. Best ratings range from A++ (Superior) to F (In Liquidation); Standard & Poor's ratings range from AAA (Extremely Strong) to R (Has Experienced Regulatory Action); Moody's ratings range from Aaa (Exceptional) to C (Lowest Rated); Fitch ratings range from AAA (Exceptionally Strong) to D (Distressed).



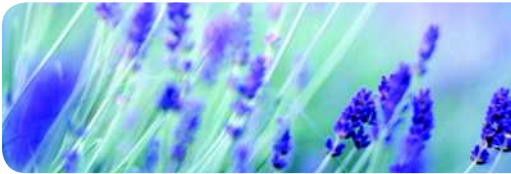
This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.  
IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

\*“Death: Leading Causes 2004,” Centers for Disease Control and Prevention, April 2006.

†“Report on Injuries in America, 2003,” National Safety Council, 2005 Edition.

## “What are the advantages of buying insurance at work?”

- **It's easy.** There are no confusing quotes to sort through. And with automatic payroll deductions, you never have to worry about late payments.
- **It's guaranteed.** If you enroll in the Supplemental Term Life plan when first hired, you may get a certain amount of coverage without having to answer any health questions or having a medical exam.
- **It's economical.** The cost of group insurance may be lower than insurance you could find on your own.
- **It's flexible.** You choose the level of coverage that's right for you.



**Customize coverage  
to fit your needs.**



“How much life insurance is enough?”

The right amount of insurance can help your family. It helps replace your income for a number of years to maintain their standard of living and pay for major financial obligations, such as a home mortgage and college tuition.

The Consumer Federation of America (CFA, 1997) recommends six to eight times your income for a married couple with children. While rules of thumb may be helpful, they do not take each individual’s personal situation into consideration. This worksheet provides a simple method to estimate the amount of life insurance you may need.

Income Needs

1. **Your annual income.** (What your family would need if you die today.)  
Enter a number that’s between 60% and 70% of your total income.

1. \$
2. **Annual replacement income.** (Available to your family after you die.)  
Enter a number that includes Social Security benefits, if applicable.

2. \$
3. **Total annual income to be replaced.** Subtract line 2 from line 1.

3. \$
4. **Funds needed to provide income for\_\_\_\_\_years.** Choose the number of years your family needs your replacement income. Multiply line 3 by the appropriate factor below.\*

4. \$

10 yrs x 8.1	15 yrs x 11.1	20 yrs x 13.6	25 yrs x 15.6	30 yrs x 17.3	35 yrs x 18.7	40 yrs x 20.0
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Expenses

5. **Burial expenses.** (The average cost of an adult funeral is about \$10,000.)

5. \$
6. **Mortgage and other major debts.** Include mortgage, credit card debt, car loan, home equity loans, etc.

6. \$
7. **College costs.** (Current cost of a four-year education: public—\$62,264; private—\$127,664.)†  
Multiply the college costs by the appropriate factor, based on the number of years between now and when your child begins college.

7. \$

5 yrs x .82	10 yrs x .68	15 yrs x .56	20 yrs x .46
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Child 1: \$

Child 2: \$

Child 3: \$

Child 4: \$

8. **Total capital required.** Add lines 4, 5, 6, and 7.

8. \$

Assets

9. **Savings and investments.** Include bank accounts, CDs, stocks, bonds, mutual funds, real estate/rental property, etc.

9. \$
10. **Retirement savings.** Include 401(k), Keogh, pension, and profit-sharing plans.

10. \$
11. **Present amount of life insurance.** Include group insurance and personal insurance purchased on your own.

11. \$
12. **Total of all assets.** Add lines 9, 10, and 11.

12. \$
13. **Estimated amount of life insurance needed.** Subtract line 12 from line 8.

13. \$

\*Inflation is assumed to be 4%. The rate of return on investments is assumed to be 8%.  
†The College Board, **Trends in College Pricing 2005**. Costs include tuition, room, board, books and supplies, transportation, and other expenses.

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions, and limitations. A Booklet-Certificate, with complete plan information, including limitations and exclusions, will be provided. You may request a Booklet-Certificate by calling the UPS Benefits Service Center at 1-800-UPS-1508. If there is a discrepancy between this document and the Booklet-Certificate issued by Prudential, the terms of the Booklet-Certificate will govern. Contract provisions may vary by state.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

**IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.**

Supplemental Term Life, Supplemental Dependent Term Life, Supplemental Accidental Death & Dismemberment Insurance, and Supplemental Dependent Accidental Death & Dismemberment coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542. Contract Series: 83500.

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**ATTENTION:**

**Here are your detachable plan details  
and rate sheets.**



# YOUR PLAN DETAILS

You Have a Lot to Protect



## UPS The Flexible Benefits Plan

Supplemental Term Life Insurance

Supplemental Dependent Term Life Insurance

Supplemental Accidental Death & Dismemberment (AD&D) Insurance

Issued by The Prudential Insurance Company of America

## Employee—Supplemental Term Life

UPS offers you the opportunity to enroll in a group Supplemental Term Life Insurance plan issued by The Prudential Insurance Company of America (Prudential). You pay the cost of this optional coverage.

Eligibility to Participate	You are eligible for coverage if you're a full- or part-time, non-union manager, supervisor, specialist, administrative, or technical employee of the company or one of its participating affiliates (except as noted in the Summary Plan Description) and your terms of employment are not subject to collective bargaining.
Coverage Amounts	You may enroll for increments of \$1,000, up to a maximum of \$1,000,000.
Guaranteed Coverage	Certain coverage is available without providing evidence of good health satisfactory to Prudential. If you enroll during your initial eligibility period, your guaranteed coverage amount equals the lesser of \$500,000 or 48 times your monthly earnings.
Medical Evidence Requirements	If you enroll after your initial eligibility period, you must provide evidence of good health satisfactory to Prudential for all coverage amounts.
Life Event Changes	If you have a change in family status such as marriage or birth (adoption), you may increase your coverage with proof of good health satisfactory to Prudential. You must notify the UPS Benefits Service Center at 1-800-UPS-1508 within 60 days of the life event.
Accelerated Benefit Option*	If you provide proof satisfactory to Prudential that you are terminally ill with a life expectancy of 12 months or less, you may elect to receive up to 50% of your Supplemental Term Life benefit (subject to a \$10,000 minimum and a \$300,000 combined Basic and Supplemental Term Life maximum or to state-regulated maximums if less) while still living. The death benefit payable will be reduced by any benefits paid under the Accelerated Benefit Option. This benefit is available once in your lifetime and is payable in a lump sum, generally income tax free (under IRC Section 101(g)).
Portability†	<p>When you leave the company, you have the opportunity to continue your group life insurance at group rates under the portability provision. Portability coverage will begin on the first day of the pay period following the date of notification of termination from UPS. Portable rates will be 120% of the rate schedule you had as an employee of UPS.</p> <p>You will be billed directly and charged a \$3 administration fee by Prudential on a quarterly basis. If UPS' participation in the master contract terminates, your portability coverage will continue. <b>You will be moved to the Prudential standard port rate structure after one year and your rates will increase.</b></p> <p>At age 70 or more, your amount of insurance is limited. It is the greater of \$10,000 and 50% of the amount for which you would then be insured if there were no limitation. At age 75 or more, your amount of insurance is further limited. It is the greater of \$10,000 and 25% of the amount for which you would then be insured if there were no limitation.</p> <p>If you use the portability provision and are later rehired or transferred to a UPS position that allows you to elect supplemental coverage under another UPS-sponsored plan, you must surrender the ported policy in order to elect coverage under the UPS-sponsored plan as an active employee.</p>
Termination of Coverage‡	Your Supplemental Term Life coverage will end when your Flexible Benefits Plan coverage ends. You have the opportunity to continue your coverage by either electing to continue your group term life coverage under the portability provision or converting to a Prudential individual life insurance policy. Additional information will be sent to you upon termination or retirement.

**\*Important Notice:** The acceleration of life insurance benefits offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986-IRC Section 101(g). If the acceleration of life insurance benefits qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to the acceleration of life income benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration of life insurance benefits excludable from income under federal law. **New York Residents:** Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

**†Minnesota Residents:** Please see the Minnesota Insert for information on continuation and conversion.

## Family—Supplemental Dependent Term Life

UPS offers you the opportunity to enroll your dependents in a group Supplemental Dependent Term Life Insurance plan issued by The Prudential Insurance Company of America (Prudential). You pay the cost of this optional coverage. Employee Supplemental Term Life Insurance coverage is not required in order for the dependent spouse, same-sex domestic partner, or civil union partner and/or dependent child(ren) to have Supplemental Term Life Insurance coverage.

### Spouse, Same-Sex Domestic Partner, or Civil Union Partner

Eligibility to Participate	If your spouse, same-sex domestic partner, civil union partner or child is eligible as an employee for Supplemental Dependent Term Life Insurance through the Flexible Benefits Plan or another UPS-sponsored plan that offers supplemental life insurance (for example, The Health and Welfare Package Select or UPS Health and Welfare Package), you are not eligible to cover your spouse, same-sex domestic partner, civil union partner or child for Supplemental Dependent Term Life Insurance through the Flexible Benefits Plan. Your spouse, same-sex domestic partner, civil union partner or child must elect employee supplemental life insurance through his or her own employee plan. If your spouse, same-sex domestic partner, civil union partner or child is confined for medical care or treatment at home or elsewhere, coverage will not begin until the confinement ceases. Please refer to the Flexible Benefits Plan Summary Plan Description for additional information regarding eligibility and when coverage begins.
Coverage Amounts	You may enroll your spouse, same-sex domestic partner, or civil union partner for coverage in amounts of \$1,000, up to a maximum of \$500,000.
Guaranteed Coverage	If your spouse, same-sex domestic partner, or civil union partner enrolls within 45 days of your date of eligibility, his/her guaranteed coverage amount is up to \$25,000.
Medical Evidence Requirements	If your spouse, same-sex domestic partner, or civil union partner is enrolled within your initial eligibility period or within 60 days of marriage, same-sex domestic partnership, or civil union, he/she must provide evidence of good health satisfactory to Prudential for coverage amounts greater than \$25,000. If your spouse, same-sex domestic partner, or civil union partner is enrolled after your initial eligibility period, he/she must provide evidence of good health satisfactory to Prudential for all coverage amounts.
Portability*	If your employment ends, and you elect to continue your coverage under the portability provision, you may also continue your Supplemental Dependent Term Life coverage for your spouse, same-sex domestic partner, or civil union partner under the portability provision. The cost of this coverage will be 120% of the rate schedule your spouse, same-sex domestic partner, or civil union partner had when you were an employee of UPS and will be guaranteed for a period of one year from the time he/she continued coverage. In the event of your death, divorce or dissolution of domestic partnership or civil union, your spouse, same-sex domestic partner, or civil union partner may continue his/her Supplemental Term Life coverage. He/she will be billed directly and charged a \$3 administration fee by Prudential on a quarterly basis. If UPS' participation in the master contract terminates, his/her portability coverage will continue. <b>You will be moved to the Prudential standard port rate structure after one year and your rates will increase.</b>
Termination of Coverage*	Your spouse's, same-sex domestic partner's, or civil union partner's Supplemental Dependent Term Life coverage will end when your Flexible Benefits Plan coverage ends. You will have the opportunity to continue coverage for your spouse, same-sex domestic partner, or civil union partner by either electing to continue group term life coverage under the portability provision or converting to a Prudential individual life insurance policy. Additional information will be sent to you upon your termination or retirement.

### Children

Eligibility to Participate†	<p>You may cover a "Child" through the end of the month in which the child turns age 26. A "Child" is defined as your natural child, your adopted child, a child placed with you for adoption or a child for whom you are the legal guardian (as determined in accordance with applicable law).</p> <p>A covered child who becomes incapacitated while covered under the Plan and before he or she turns age 26 is eligible to continue coverage after turning age 26 as long as you are eligible and as long as the following conditions are satisfied: (i) the incapacity exists, (ii) the child is unmarried, (iii) the child is primarily dependent on you for support and maintenance and (iv) appropriate certification of disability is provided to the medical claims administrator. You must apply to continue coverage for an incapacitated dependent prior to age 26 or loss of coverage under the Plan. In addition, periodic medical documentation of the continuing incapacity is required as determined by the medical claims administrator.</p>
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\*Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.

†Dependent Child Eligibility: If a dependent child is confined for medical care or treatment at home or elsewhere, the coverage will begin when confinement ceases. Confinement does not apply to an adopted child or child placed prior to adoption.



### Family—Supplemental Dependent Term Life (continued)

Coverage Amounts	You may enroll your dependent children for increments of \$1,000, up to a maximum of \$30,000. Children Dependent Term Life coverage has one premium rate that covers all eligible children.
Termination of Coverage*	Your dependent children's Supplemental Dependent Term Life coverage will end when The Flexible Benefits Plan coverage ends. You have the opportunity to continue coverage for your children if you elect to continue your coverage under the portability provision or convert to a Prudential individual life policy. Child-only portable coverage is not permissible. Additional information will be sent to you upon your termination or retirement.

\*Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.

## Employee and Dependent—Supplemental Accidental Death & Dismemberment (Supplemental AD&D)

UPS offers you the opportunity to enroll in a group Supplemental AD&D Insurance plan (also known as Personal Accident Insurance), issued by The Prudential Insurance Company of America (Prudential). Supplemental AD&D provides a benefit for loss of life and certain injuries resulting from a covered accident. Loss of life benefits are paid in addition to Supplemental Term Life. You pay the cost of this optional coverage.

Eligibility to Participate	You are eligible for coverage if you're a full- or part-time, non-union manager, supervisor, specialist, administrative or technical employee of the company or one of its participating affiliates (except as noted in the Summary Plan Description) and your terms of employment are not subject to collective bargaining. Your spouse, same-sex domestic partner, or civil union partner and dependent children are eligible if you are enrolled in Supplemental AD&D.									
Employee Coverage Amounts	You may enroll for coverage in increments of \$1,000, up to a maximum of \$1,000,000.									
Coverage Options	<p><b>If you elect employee coverage only</b>, you will receive the Standard Benefits and the Additional Benefits listed below. If you elect this option, your dependents (family) will not be covered.</p> <p><b>If you elect employee and dependents (family) coverage</b>, you will receive the Standard Benefits, Additional Benefits, and Additional Family Benefits and Services listed below and on the following pages.</p> <p>You may not elect dependent (family) coverage only.</p>									
Family Coverage Amounts	<p>With Supplemental AD&amp;D, the benefit amounts for your family are predetermined by the dependent class you choose to cover and are a function of the employee's coverage amount.</p> <table><thead><tr><th>Covered Dependent Class</th><th>Benefit Amount</th></tr></thead><tbody><tr><td>Employee and Spouse, Same-Sex Domestic Partner, or Civil Union Partner only</td><td>70% of the employee coverage amount</td></tr><tr><td>Employee and Child(ren) only</td><td>50% of the employee coverage amount for each child (maximum \$50,000)</td></tr><tr><td>Employee, Spouse, Same-Sex Domestic Partner, or Civil Union Partner and Child(ren)</td><td>60% of the employee coverage amount for the spouse, same-sex domestic partner, or civil union partner, 25% of the employee coverage amount for each child (maximum \$50,000)</td></tr></tbody></table>		Covered Dependent Class	Benefit Amount	Employee and Spouse, Same-Sex Domestic Partner, or Civil Union Partner only	70% of the employee coverage amount	Employee and Child(ren) only	50% of the employee coverage amount for each child (maximum \$50,000)	Employee, Spouse, Same-Sex Domestic Partner, or Civil Union Partner and Child(ren)	60% of the employee coverage amount for the spouse, same-sex domestic partner, or civil union partner, 25% of the employee coverage amount for each child (maximum \$50,000)
Covered Dependent Class	Benefit Amount									
Employee and Spouse, Same-Sex Domestic Partner, or Civil Union Partner only	70% of the employee coverage amount									
Employee and Child(ren) only	50% of the employee coverage amount for each child (maximum \$50,000)									
Employee, Spouse, Same-Sex Domestic Partner, or Civil Union Partner and Child(ren)	60% of the employee coverage amount for the spouse, same-sex domestic partner, or civil union partner, 25% of the employee coverage amount for each child (maximum \$50,000)									

### Standard Benefits

Benefits are paid at certain percentages of your coverage amount for specific accidental losses as indicated below. Not more than 100% of your coverage amount is payable for all losses due to the same accident. The loss must be incurred within 90 days of the accident (paralysis within 365 days of the accident).

	Accidental Losses	Benefits
	Life	100%
	Sight in both eyes	100%
	Both hands or both feet	100%
	One hand and one foot	100%
	One hand or one foot and sight in one eye	100%
	Quadriplegia	100%
	Speech and hearing in both ears	100%
	Paraplegia	75%
	Hemiplegia	75%
	One hand or one foot	75%
	Sight in one eye	75%
	Speech	75%
	Hearing in both ears	75%
	Thumb and index finger on the same hand	50%
	Uniplegia	50%
Loss Due to Exposure and Disappearance	Loss due to exposure to the elements or disappearance is considered an accidental loss. The plan pays 100% of your coverage amount if you or your covered dependent's body is not found within a year of a certain disappearance because you or your covered dependent will be presumed to have died.	

## Employee and Dependent—Supplemental AD&D (continued)

Loss Due to Coma	The plan pays 1% of your coverage amount for each month you, or your covered dependent, remain in a coma that results from a covered accident. The coma must be total, continuous, permanent, begin within three days of the accident, and last for six months. This benefit is payable for up to 100 months while you remain in a coma.
Permanent and Total Disability Benefit	The plan pays a benefit of 100% of the coverage amount if you or your covered dependent are under age 70 and sustain a permanent and total disability within 100 days after a covered accident.
Brain Damage Benefit	The plan pays 100% of the coverage amount if you or your covered dependent sustain brain damage within 60 days of a covered accident. You must be hospitalized for at least seven days within the first 60 days following the covered accident and brain damage must continue for 12 consecutive months and must be non-reversible after that time.
<b>Additional Benefits</b> These benefits are paid in addition to the Standard and Additional Benefits only if you elect family coverage.	
Seat Belt Benefit	The plan pays an additional benefit of 10% of the coverage amount, up to \$25,000, if an accidental death occurs while you or your covered dependent are wearing a seat belt in the prescribed manner.
Air Bag Benefit	The plan pays an additional benefit of 10% of the coverage amount, up to \$25,000, if an accidental death occurs while you or your covered dependent are riding in an automobile seat equipped with an air bag system, and you or your covered dependent are wearing a seat belt in the prescribed manner.
Rehabilitation Benefit	The plan pays 20% of the coverage amount, to a maximum of \$10,000, for necessary expenses incurred within two years of the accident, if you or your covered dependent suffer a loss as the result of a covered accident and require training to return to work or to become independent.
Continuation of Medical Funding Benefit	The plan pays three annual installments, up to 5% of the coverage amount (maximum \$10,000), to continue medical coverage for the family if you or your covered dependent die as the result of a covered accident. This benefit is to begin after the 13-month extension of health care benefit coverage provided by The Flexible Benefits Plan. If the beneficiary does not provide proof that the payment was used for the purchase of medical coverage, the beneficiary will receive only one payment of 5% or \$10,000, whichever is less.
Home Modification Benefit	The plan pays up to \$2,000 for required home site changes made within one year of the accident, if you or your covered dependent suffer a loss as the result of a covered accident.
Emergency Medical Evacuation/ Return of Remains Service	The plan pays for emergency medical evacuation for you or your covered dependent to a suitable medical facility upon orders from an attending physician, or the preparation and transportation of your or your covered dependent's body for cremation or burial if your (or your covered dependent's) death occurs outside a 150-mile radius of your home. The amount is the lesser of the actual covered expenses or \$2,500.

## Employee and Dependent—Supplemental AD&D (continued)

### Additional Family Benefits

These benefits are paid in addition to the Standard and Additional Benefits only if you elect family coverage.

Spouse/Same-Sex Domestic Partner/ Civil Union Partner Tuition Reimbursement Benefit	The plan pays a tuition reimbursement benefit for a professional or trade program to prepare your spouse, same-sex domestic partner, or civil union partner for work if you die in a covered accident. This benefit is the actual tuition incurred to a maximum of \$15,000. Expenses must be incurred within 30 months of your death.
Child Tuition Reimbursement Benefit	The plan pays a tuition reimbursement benefit for a dependent child if you or your spouse, same-sex domestic partner, or civil union partner die in a covered accident. The annual benefit is the lesser of the actual tuition, excluding room and board, 10% of your coverage amount, or \$80,000. It is payable for up to four years for a dependent child less than age 23, provided the child was a full-time student enrolled in an institution of higher learning, or is in high school or becomes enrolled within 365 days of your death. This benefit is paid to your spouse, same-sex domestic partner, or civil union partner or the child's legal guardian if the child is under age by state law. If no child qualifies for this benefit, the plan pays 1% of your coverage amount to a maximum of \$2,000 to your beneficiary.
Day Care Expense Benefit	The plan pays a day care reimbursement benefit for a dependent child if you or your spouse, same-sex domestic partner, or civil union partner die in a covered accident. The annual benefit is the lesser of the actual day care cost, 5% of your coverage amount, or \$7,500. This benefit is payable for up to four consecutive years for a dependent child, until that child reaches age seven, provided the child is enrolled in a licensed or certified day care center on the date of death, or within 90 days of that date. This benefit is paid to you or your spouse, same-sex domestic partner, or civil union partner or the child's legal guardian. If no child qualifies for this benefit, the plan pays \$2,000 to your beneficiary.
Common Accident Benefit	The plan pays a benefit for the death of your spouse, same-sex domestic partner, or civil union partner if you and your spouse, same-sex domestic partner, or civil union partner both die within 90 days as a result of the same accident. This benefit is the difference between your coverage amount and your spouse's, same-sex domestic partner's, or civil union partner's coverage amount.
Termination of Coverage	Your Supplemental AD&D coverage will end when your Flexible Benefits Plan coverage ends.
Exclusions	<p>A loss is not covered if it results from any of these:</p> <ul style="list-style-type: none"> <li>■ Suicide, attempted suicide, while sane or insane;</li> <li>■ Intentionally self-inflicted injuries or any attempt to inflict such injuries, while sane or insane;</li> <li>■ Sickness, whether the loss results directly or indirectly from the sickness;</li> <li>■ Medical or surgical treatment of sickness, whether loss results directly or indirectly from treatment;</li> <li>■ Any infection (unless pyogenic resulting from an accident or a bacterial infection that results from accidental ingestion of a contaminated substance);</li> <li>■ War, or any act of war, declared or undeclared, and includes resistance to armed aggression;</li> <li>■ Accident that occurs while serving on full-time active duty for more than 30 days in any armed forces (does not include Reserves or National Guard; active duty for training); or</li> <li>■ Commission of, or attempt to commit, a felony;</li> <li>■ Legal intoxication; or</li> <li>■ Use of narcotics (unless administered or consumed on a doctor's advice).</li> </ul>
Important Notice for New York Residents	<p>This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.</p> <p><b>IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.</b></p>

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions, and limitations. A Booklet-Certificate, with complete plan information, including limitations and exclusions, will be provided. You may request a Booklet-Certificate by calling the UPS Benefits Service Center at 1-800-UPS-1508. If there is a discrepancy between this document and the Booklet-Certificate issued by Prudential, the terms of the Booklet-Certificate will govern. Contract provisions may vary by state.

Supplemental Term Life, Supplemental Dependent Term Life, Supplemental Accidental Death & Dismemberment, and Supplemental Dependent Accidental Death & Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542. Contract Series: 83500.

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## Rate Sheet

### The Flexible Benefits Plan

Effective Date: January 1, 2014

#### Supplemental Term Life— Employee and Spouse, Same-Sex Domestic Partner, or Civil Union Partner

Annual Cost of Insurance (rates per \$1,000 of coverage)

Age (As of January 1 of coverage year)	Annual Non-Smoker Rates	Annual Smoker Rates
Under 30	\$0.42	\$0.61
30–34	\$0.42	\$0.61
35–39	\$0.48	\$0.70
40–44	\$0.70	\$1.10
45–49	\$1.24	\$1.93
50–54	\$2.15	\$3.02
55–59	\$3.46	\$4.97
60–64	\$5.78	\$8.33
65–69	\$10.06	\$14.39
70–74	\$18.86	\$27.05
75–79	\$29.88	\$42.88
80–84	\$42.06	\$60.37
85–89	\$60.52	\$86.80
90–94	\$87.70	\$125.83
95+	\$103.43	\$146.48

#### “How much does Supplemental Dependent Term Life— Employee and Spouse/Same-Sex Domestic Partner/Civil Union Partner cost?”

<b>Step 1</b>	Enter the amount of coverage you wish to purchase (increments of \$1,000, not to exceed \$1,000,000 for yourself; not to exceed \$500,000 for your spouse, same-sex domestic partner, or civil union partner).	\$
<b>Step 2</b>	Divide the coverage amount by \$1,000.	\$
<b>Step 3</b>	Multiply the amount in Step 2 by the cost of coverage that you'll find in the chart above.	\$
<b>Step 4</b>	If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost.	\$
<b>TOTAL COST</b>		\$

#### Supplemental Dependent Term Life—Children

(Premium covers all eligible children)

Coverage Child(ren)	Annual Cost of Insurance
	\$0.74

#### “How much does Supplemental Dependent Term Life—Children cost?”

<b>Step 1</b>	Enter the amount of coverage you wish to purchase (increments of \$1,000, not to exceed \$30,000).	\$
<b>Step 2</b>	Divide the coverage amount by \$1,000.	\$
<b>Step 3</b>	Multiply the amount in Step 2 by .74.	\$
<b>Step 4</b>	If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost.	\$
<b>TOTAL COST</b>		\$

All coverages are optional, and the entire cost of coverage is employee paid.

Rates may change as the insured enters a higher age category, also rates may change if plan experience requires a change for all insureds.

Cost of insurance rates for all coverages will be deducted from your paycheck. Please note that a summary of plan provisions, exclusions, and limitations is listed on the plan details portion of this kit. All provisions that apply to this coverage are governed by the Booklet-Certificate.

## Rate Sheet

### The Flexible Benefits Plan

Effective Date: January 1, 2014

#### Supplemental Accidental Death & Dismemberment

Annual Cost of Insurance (rates per \$1,000 of coverage, regardless of age or smoker/non-smoker status)

Insured	Annual Rates
Employee	\$0.25
Employee and Dependents	\$0.42

#### “How much does Supplemental Accidental Death & Dismemberment coverage cost?”

<b>Step 1</b>	Enter the amount of coverage you wish to purchase (coverage is available in increments of \$1,000, not to exceed \$1,000,000)	\$
<b>Step 2</b>	Divide the coverage amount by \$1,000.	\$
<b>Step 3</b>	Multiply the amount in Step 2 by .25 if you are purchasing coverage for yourself only. Multiply the amount in Step 2 by .42 if you are purchasing coverage for yourself and your dependents.	\$
<b>Step 4</b>	If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost.	\$
<b>TOTAL COST</b>		\$

**All coverages are optional, and the entire cost of coverage is employee paid.**

Rates may change as the insured enters a higher age category, also rates may change if plan experience requires a change for all insureds. Cost of insurance rates for all coverages will be deducted from your paycheck. Please note that a summary of plan provisions, exclusions, and limitations are listed on the plan details portion of this kit. All provisions that apply to this coverage are governed by the Booklet-Certificate.

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## **The Flexible Benefits Plan**

### **Important Notice for Minnesota Residents**

#### **The Prudential Insurance Company of America**

For Minnesota residents, there are different provisions that apply about your right to continue or convert coverage after your insurance ends. This notice replaces the descriptions of portability and termination of coverage in the “Help Protect the Most Important People in Your Life” brochure and “Your Plan Details” contained in this kit.

#### **Employee—Supplemental Term Life**

##### **Continuation of Coverage**

You have the right to continue your Supplemental Employee Term Life coverage under the Group Contract at your expense if your Flexible Benefits Plan coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS’ contract with The Prudential Insurance Company of America terminates.

If your continued coverage ends because the UPS contract ends, you may convert all or part of your insurance to an individual life insurance contract (see below).

##### **Conversion**

Your Supplemental Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all term life insurance of the Group Contract for your class ends by amendment or otherwise. You have an opportunity to continue your Supplemental Term Life coverage by converting to an individual life insurance contract. The individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

Additional information will be sent to you upon termination or retirement.

#### **Family—Supplemental Dependent Term Life**

##### **Spouse, Same-Sex Domestic Partner, or Civil Union Partner**

##### **Continuation of Coverage**

You have the right to continue your spouse’s, same-sex domestic partner’s, or civil union partner’s Supplemental Dependent Term Life coverage under the Group Contract at your expense if your Flexible Benefits Plan coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS’ contract with The Prudential Insurance Company of America terminates.

In the event of your death, divorce or dissolution of domestic partnership or civil union, your spouse, same-sex domestic partner, or civil union partner may continue his/her Supplemental Dependent Term Life coverage. Your spouse, same-sex domestic partner, or civil union partner will be billed directly. If UPS’ contract with The Prudential Insurance Company of America terminates, your spouse’s, same-sex domestic partner’s, or civil union partner’s continued coverage will end.



If continued coverage for your spouse, same-sex domestic partner, or civil union partner ends because the UPS contract ends, you may convert all or part of your spouse's, same-sex domestic partner's, or civil union partner's insurance to an individual life insurance contract (see below).

### **Conversion**

Your spouse's, same-sex domestic partner's, or civil union partner's Supplemental Dependent Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all Term Life Insurance of the Group Contract for your class ends by amendment or otherwise. You have an opportunity to continue your spouse's, same-sex domestic partner's, or civil union partner's Supplemental Dependent Term Life coverage by converting your spouse's, same-sex domestic partner's, or civil union partner's coverage to an individual life insurance contract. Your spouse, same-sex domestic partner, or civil union partner may elect to convert (rather than continue) her/his Supplemental Dependent Term Life coverage to an individual life insurance contract in the event of death or divorce. The individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

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### **Children**

#### **Continuation of Coverage**

You have the right to continue your children's Supplemental Dependent Term Life coverage under the Group Contract at your expense if your Flexible Benefits Plan coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS' contract with The Prudential Insurance Company of America terminates.

If continued coverage for your children ends because the UPS contract ends, you may convert all or part of each of your children's insurance to an individual life insurance contract (see below).

### **Conversion**

Your children's Supplemental Dependent Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all Term Life Insurance of the Group Contract for your class ends by amendment or otherwise, or (3) your child ceases to be a qualified dependent. You have an opportunity to continue your children's Supplemental Dependent Term Life coverage by converting each of your children's coverage to an individual life insurance contract. Each individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

Additional information will be sent to you upon termination or retirement.

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This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

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## NOTES



